

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05080

05089

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL FINKSBURG c. LENGTH OF STAY IN 1b 14 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ROUTE #7				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL FINKSBURG d. STREET ADDRESS ROUTE #1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLAUDE COE ARMACOST				4. DATE OF DEATH Month Day Year APRIL 10 1966			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 1, 1896	
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY UNITED STATES	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING			
11. BIRTHPLACE (County & State, or foreign country) CARROLL CO., MD.				12. CITIZEN OF WHAT COUNTRY UNITED STATES			
13. FATHER'S NAME JOHN DANIEL ARMACOST				14. MOTHER'S MAIDEN NAME LILLIAN GERTRUDE CONSTANTINE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 214-28-1055			
17. INFORMANT GEORGE ARMACOST				18. ADDRESS ROUTE #1 FINKSBURG MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input checked="" type="checkbox"/> DUE TO (c) <input type="checkbox"/> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 1966 to APRIL 1966 that (I) (we) last saw the deceased alive on APRIL 10, 1966 , and that death occurred at 235 M, from the causes and on the date stated above.							
22a. SIGNATURE Daniel I Welliver M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/10/66	
22c. PHYSICIAN'S NAME DANIEL I. WELLIVER				22d. ADDRESS 19 RIDGE RD WESTMINSTER, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/13/66		23c. NAME OF CEMETERY OR CREMATORY Finksbury Church Cemetery, Finksbury, Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE S. E. Meyer, Jr., Westminster, Md.				25a. REC'D BY REGISTRAR APR 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0515

W. J. HARRIS

W. J. HARRIS

THE FARMER IN YEAR 1900

W. J. HARRIS

CLAUDE E. HARRIS

W. J. HARRIS

FARMER HARRIS

JOHN HARRIS

W. J. HARRIS

CARROLL HARRIS

W. J. HARRIS

W. J. HARRIS

W. J. HARRIS

FARMER HARRIS

W. J. HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER MD.</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER MD.</u>						
c. LENGTH OF STAY IN 1b <u>7 YRS.</u>					d. STREET ADDRESS <u>56 CARROLL ST</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>56 CARROLL STREET</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>NELLIE AGNES ARNOLD</u>					4. DATE OF DEATH <u>APRIL 27</u> 19 <u>66</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 14, 1898</u>		9. AGE (in years last birthday) <u>68</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WESTMINSTER, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOHN E. RICKLE</u>					14. MOTHER'S MAIDEN NAME <u>MARY E. HARMAN</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>213-24-8076</u>		17. INFORMANT <u>HUSBAND EBEN R. ARNOLD</u>			Address <u>56 CARROLL ST. WESTMINSTER, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>OUT TO</u> <u>Arteriosclerotic Heart Disease</u> <u>24 years</u> <u>OUT TO</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>64</u> , to <u>April 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 26</u> , 19 <u>66</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>John S. Harsley</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/27/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSLEY</u>					22d. ADDRESS <u>8 ANCHOR ST. WESTMINSTER MD.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>4/30/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN MEMORIAL</u>		23d. LOCATION (City, town or county) (State) <u>FINKSBURG, MD.</u>				
24. FUNERAL DIRECTOR <u>Thomas C. Safford</u>					ADDRESS <u>WESTMINSTER, MD.</u>		25a. REC'D BY REGISTRAR <u>APR 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

1913

[Faint, illegible handwriting throughout the page]

APR 25 1913

05092

CERTIFICATE OF DEATH

05093

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Union Bridge RD #1 c. LENGTH OF STAY IN 1b 50 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge RD #1 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ADA Middle ELIZABETH Last BABYLON			4. DATE OF DEATH Month April Day 4 Year 1966				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1886	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Carroll Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Warehime			14. MOTHER'S MAIDEN NAME Emma Bankert				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Noah H. Babylon same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1533 Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma - sigmoid. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 11/20/1965 19 to 4/14/1966 19 , that (I) was saw the deceased alive on 4/11/1966 19 , and that death occurred at 3:30 P , from the causes and on the date stated above.							
22a. SIGNATURE M.E. Robertson			22b. DATE SIGNED 4/14/1966		22c. PHYSICIAN'S NAME (Type) M.E. Robertson		
22d. ADDRESS New Windsor, Md.			22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 4/7/66	23c. NAME OF CEMETERY OR CREMATORY Baust Church Cemetery	23d. LOCATION (City, town or county) (State) Union Bridge RD1 Md.				
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr.			25a. REC'D BY REGISTRAR APR 6 1966				
25b. REGISTRAR'S SIGNATURE J. Charles Judge							

05093

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Apr 6 1980

DEATH CERTIFICATE

1902

1902

Blank form area for death certificate details, including fields for name, age, sex, cause of death, and date of death.

1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

05094

CERTIFICATE OF DEATH

05092

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 9 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RUSSELL RODNEY BARBE		4. DATE OF DEATH Month Day Year APRIL 23 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-1892
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME A. Frank Barbe		14. MOTHER'S MAIDEN NAME Mary Jane Nissberodt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes (Unk.)		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 4200 DUE TO Arteriosclerotic heart disease (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-14-66 , 19__, to 4-23-66 , 19__, that (I) (we) last saw the deceased alive on 4-23-66 , 19__, and that death occurred at 1:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 4-25-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-29-66	
23c. NAME OF CEMETERY OR CREMATORY Stony Creek		23d. LOCATION (City or Town) (County) (State) Stony Creek Springs	
24. FUNERAL DIRECTOR Arthur H. Haight Sykesville, Md.		25a. REC'D BY REGISTRAR APR 29 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

2105

221

Physiology

1950-1951 40-41

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455

1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812

Table 10.10 (continued)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
05095										
05094										
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg			c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg			d. STREET ADDRESS School House Lane		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) School House Lane					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Albert Middle W. Last Bean					4. DATE OF DEATH Month April Day 22 Year 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 3, 1885		9. AGE (In years last birthday) 81 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Carroll Co., Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George T. Bean					14. MOTHER'S MAIDEN NAME Savilla Warfield					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Earl F. Mann			Address Finksburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Arteriosclerotic C.V. Disease								INTERVAL BETWEEN ONSET AND DEATH 48 hrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric ulcer								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Sept. 28, 1950 to April 22, 1966 that (I) (we) last saw the deceased alive on April 20, 1966 , and that death occurred at 8 PM , from the causes and on the date stated above.										
22a. SIGNATURE Martin E. Strobel					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 4-23-66		
22c. PHYSICIAN'S NAME (Type) Martin E. Strobel, M.D.					22d. ADDRESS 48 Main St. Reisterstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/66		23c. NAME OF CEMETERY OR CREMATORY Deer Park Methodist Cem. Reisterstown, Md.			23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers, Jr.					ADDRESS Westminster, Md.		25a. REC'D BY REGISTRAR APR 27 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05096

CERTIFICATE OF DEATH

05095

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville 151 W. All Saints St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Frederick 10-2	
3. NAME OF DECEASED (Type or print) First Carrie Middle Amelia Last Bentley		4. DATE OF DEATH Month April Day 30 Year 1966	
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 25, 1880
9. AGE (In years last birthday) yrs. 86		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Bentley		14. MOTHER'S MAIDEN NAME Susan Skinner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Springfield Hospital Records, Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) YEARS		INTERVAL BETWEEN ONSET AND DEATH DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC BRAIN SYNDROME WITH SENILE BRAIN DISEASE WITH PSYCHOTIC REACTION		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) F	20f. (City or town) (County) (State) 4/30/66
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4-22- 19 66 to 4/30/66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4-30- 19 66 , and that death occurred at 12:40 A.M. from causes and on the date stated above.			
22a. SIGNATURE R. G. Lejonchere MD		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) R. G. Lejonchere - M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/3/66	23c. NAME OF CEMETERY OR CREMATORY Fairview	23d. LOCATION (City or Town) (County) (State) Frederick Frederick, Md
24. FUNERAL DIRECTOR C.E. Hicks, III		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		MAY 3 1966	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05097

CERTIFICATE OF DEATH

05096

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN lb 38y. 5m. 4d.		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		21-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS --		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		?		
3. NAME OF DECEASED (Type or print) First Roberta Middle ? Last Bishop		4. DATE OF DEATH Month 4 Day 11 Year 19 66		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/11/87	
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Bishop		14. MOTHER'S MAIDEN NAME Alice Besare		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		
17. INFORMANT Springfield Hospital records-Sykesville		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic congestive heart failure DUE TO 410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Mitral calcification and stenosis DUE TO (c) Chronic rheumatic heart disease				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type. Gen. Arteriosclerosis				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from 11/7/ , 19 67 , to 4/11/ , 19 66 , that (if) (we) last saw the deceased alive on 4/11/ , 19 66 , and that death occurred at 10:40 p.m. from causes and on the date stated above.				
22a. SIGNATURE Edmee J. Reeves		22b. DATE SIGNED 4/11/66		
22c. PHYSICIAN'S NAME (Type) Edmee J. Reeves, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-14-66		23b. DATE THEREOF SMITHSBURG		
23c. NAME OF CEMETERY OR CREMATORY SMITHSBURG WASH		23d. LOCATION (City or Town) (County) (State) WASH D.C.		
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown		25a. REC'D BY REGISTRAR APR 15 1966		
25b. REGISTRAR'S SIGNATURE Charles Judge				

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05098

CERTIFICATE OF DEATH

05097

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 10mos.28dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2030 Edmondson Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALEXANDER (NMN) BLACKWELL		4. DATE OF DEATH Month APRIL Day 19 Year 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unk. 9. AGE (In years last birthday) yrs. 81?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eli Blackwell	
14. MOTHER'S MAIDEN NAME Mary (last name unk.)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) Unk.	
16. SOCIAL SECURITY NO. 217-01-0670		17. INFORMANT Records, Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Weeks Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis, without qualifying phrase			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 5-21-65 , 19____ to 4-19-66 , 19____, that (I) (we) last saw the deceased alive on 4-19-66 , 19____, and that death occurred at 5:20 PM , 19____, from causes and on the date stated above.	
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 4-20-66	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 4-22-66	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore md
24. FUNERAL DIRECTOR Kennell B. Oden - Baltimore, md		25a. REC'D BY REGISTRAR APR 21 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05099

CERTIFICATE OF DEATH

05098

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yr 6mo 18da	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 1312 Dennis Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last James Meredith Blackwell		4. DATE OF DEATH Month Day Year April 16- 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-78
9. AGE (In years last birthday) 88		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Catherine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 223-03-6053	
17. INFORMANT Springfield Hosp. Records		Address Sykesville Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Arteriosclerotic Cardio-vascular disease Beginning gangrene (b) DUE TO Advanced Generalized Arteriosclerosis (c) Pulmonary tuberculosis Chronic Brain Syndrome Associated with cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH Years Weeks Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 0021			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-28-63 , 19__, to 4-16-66 , 19__, that (I) (we) last saw the deceased alive on 4-16-66 , 19__, and that death occurred at 8:45AM , from causes on and on the date stated above.			
22a. SIGNATURE Dr. Antonius Glahn		22b. DATE SIGNED 4-16-66	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, Md.		22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-19-66	23c. NAME OF CEMETERY OR CREMATORY Lexington Cemetery	23d. LOCATION (City or Town) (County) (State) Lexington VA
24. FUNERAL DIRECTOR Harry W. Haight		25a. BY REGISTRAR APR 19 1966	
ADDRESS Sykesville, Md.		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2420

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
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05099											
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>94m</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> <u>06-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>21 WARD AVE</u>						d. STREET ADDRESS <u>21 WARD AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAZIE</u>			First <u>MAZIE</u>			Middle <u>KOPP</u>			Last <u>BLOCHE</u>		
4. DATE OF DEATH Month <u>APRIL</u> Day <u>3</u> Year <u>1966</u>			5. SEX <u>female</u>			6. COLOR OR RACE <u>white</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>Sept 4 1894</u>			9. AGE (In years last birthday) <u>71</u> yrs.			10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>			11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn N.Y.</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.-C.</u>						13. FATHER'S NAME <u>Louis Kopp</u>			14. MOTHER'S MAIDEN NAME <u>Susanna Jacoby</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>						16. SOCIAL SECURITY NO. <u>-</u>			17. INFORMANT <u>Mrs. Alta K. Quayle</u> <u>935 Monument Ave. Balt. 18. Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>											
4201 DUE TO (b) <u>CORONARY ATHEROSCLEROSIS</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>7 YEARS</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 1959</u> to <u>APRIL 3, 1966</u> , that (I) (we) last saw the deceased alive on <u>APRIL 1, 1966</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.											
22e. SIGNATURE <u>William J. Stewart</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>4/3/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>William J. Stewart</u>						22d. ADDRESS <u>19 RIDGE RD. WESTMINSTER, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>4/6/66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr. Westminister, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 6 1966</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

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CERTIFICATE OF DEATH

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05101

CERTIFICATE OF DEATH

05100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG</u> c. LENGTH OF STAY IN b <u>9 MONTHS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BROOKFIELD MANOR N. H.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> f. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> d. STREET ADDRESS <u>RURAL</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ELEANORE LOGSDON BROWN</u>				4. DATE OF DEATH <u>APRIL 9 1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-28-1872</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>JOHN LOGSDON</u>				14. MOTHER'S MAIDEN NAME <u>LAURA COLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. MAMIE ERB, WESTMINSTER, M.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebrovascular accident</u> <u>331X</u> DUE TO <u>General Cerebroarteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>3 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 5 1965</u> to <u>Apr 9 1966</u> , that (I) (we) last saw the deceased alive on <u>Apr 9 1966</u> , and that death occurred at <u>2:34 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Julius Chapko</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Julius Chapko</u>				22d. ADDRESS <u>8514 Green St, Westminister, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>BURIAL</u>		<u>4-11-66</u>		<u>METHODIST CEM. UNION TOWN, MD.</u>		<u>UNION TOWN, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>D. Hartzler & Sons</u>				ADDRESS <u>UNION BRIDGE MD</u>		25a. REC'D BY REGISTRAR <u>APR 12 1966</u> 25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05102

05101

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>					
c. LENGTH OF STAY IN 1b <u>10 yrs.</u>				d. STREET ADDRESS <u>295 East Main St.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>295 East Main St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE WILLIAM BROWN</u>				4. DATE OF DEATH Month Day Year <u>APRIL 18 1966</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4, 1890</u>			
9. AGE (In years last birthday) <u>75</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>traffic engineer, rapid transit</u>				10b. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME <u>George Richard Brown</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Krick</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>193-20-1660</u>					
17. INFORMANT <u>Mrs Florence F. Brown</u>				Address <u>Same address</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5702</u> DUE TO <u>mesenteric Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerotic Heart Disease Pulmonary emphysema</u>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 26, 1963</u> , to <u>April 18, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 17, 1966</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>John S. Harshey</u>				22b. DATE SIGNED <u>4/18/66</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>			
22d. ADDRESS <u>BANCHOR ST. WESTMINSTER, MD.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery Westminster, Md.</u>		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr.</u>				25a. REC'D BY REGISTRAR <u>APR 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



Presbyterian Church

Centennial of the Church of Scotland

John's Church
1844-1944
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05103									
05102									
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 1 mo. 28 dys. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2916 Harford Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Aloysius BROWN					4. DATE OF DEATH Month Day Year April 29 19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-28-98		9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (retired)				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Brown					14. MOTHER'S MAIDEN NAME Kitty Cant				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 012-05-0820		17. INFORMANT Records, Springfield State Hospital Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PERIPHERAL ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 1 year YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3-1-66 , 19__, to 4-29-66 , 19__, that (I) (we) last saw the deceased alive on 4/29 , 19 66 , and that death occurred at 11:50 AM , from the causes and on the date stated above.									
22a. SIGNATURE Samuel P. Wise, III					22b. DATE SIGNED 4-29-66				
22c. PHYSICIAN'S NAME (Type) Samuel P. Wise, III, M.D.					22d. ADDRESS Springfield State Hospital, Sykesville, Maryland 21781				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5-2-66		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Arthur H. Haight					25a. REC'D BY REGISTRAR Charles Judge				
25b. REGISTRAR'S SIGNATURE Charles Judge					DATE MAY 3 1966				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MAYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville c. LENGTH OF STAY IN 1b Oy Om 13d d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City 21217 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 30-4 d. STREET ADDRESS Argyle Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JAMES Christopher CARTER					4. DATE OF DEATH Month 4 Day 29 Year 19 66				
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-7-75		9. AGE (In years last birthday) 90 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) unknown Md.		12. CITIZEN OF WHAT COUNTRY? -- USA	
13. FATHER'S NAME unknown					14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown			16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, Sykesville, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis									
19. INTERVAL BETWEEN ONSET AND DEATH 13 days									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) ---				
20c. TIME OF INJURY Month, Day, Year Hour a.m. -- p.m. -- 19 66			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State) --		
21. I certify that the (this hospital) attended the deceased from 4-16 , 19 66 , to 4-29 , 19 66 , that the (we) last saw the deceased alive on 4/29 , 19 66 , and that death occurred at 12:30 AM , from the causes and on the date stated above.									
22a. SIGNATURE SP Wise III					22b. DATE SIGNED 4-29-66				
22c. PHYSICIAN'S NAME (Type) Sam P. Wise III					22d. ADDRESS Springfield State Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5-4-66		23c. NAME OF CEMETERY OR CREMATORY Sharp Street.		23d. LOCATION (City, town or county) (State) Sandy Spring, Md.		
24. FUNERAL DIRECTOR Robert Howard Robinson					25a. REC'D BY REGISTRAR April 29-66				
					25b. REGISTRAR'S SIGNATURE Charles Judge				

MAY 3 1966

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MAY 3 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 15105

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 10 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pullen Nursing Home</u>		d. STREET ADDRESS <u>Route 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>A.</u> Last <u>Conaway</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1886</u>
9. AGE (In years last birthday) <u>80</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Pickett</u>		14. MOTHER'S MAIDEN NAME <u>Eliza J. Penn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Arthur R. Conaway</u>		Address <u>Same As Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage, Hemiplegia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, Arteriosclerosis, generalized;</u> DUE TO (c) <u>Coronary thrombosis, Cardiac failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1965</u> <u>through</u> <u>4.13.66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 65</u> to <u>4.13.66</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>April 13</u> , 19 <u>66</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sykesville, Maryland</u> DATE SIGNED <u>April 14, 1966</u>			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/16/1966</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Winfield Church Of God</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u>		24. REC'D BY REGISTRAR <u>APR 18 1966</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05106											
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster, Md. c. LENGTH OF STAY IN 1b 1 1/2 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Meadow View Nursing Home Westminster, Md. R. D. 1						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Westminster, Md. d. STREET ADDRESS Westminster, Md. R. D. 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Garfield			First David			Middle David			Last Crowl		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 25, 1880		9. AGE (In years last birthday) 85		10. IF FUNERAL 1 YEAR Months Oays Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME David Crowl						14. MOTHER'S MAIDEN NAME Julia Bankert					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 219-01-4517A		17. INFORMANT Bethel M. Smith, 400 Baltimore St. Hanover, Pa.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema 5271 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Semility 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec 16, 1965 , to April 27, 1966 , that (I) (we) last saw the deceased alive on April 26, 1966 , and that death occurred at 555 AM , from the causes and on the date stated above.											
22a. SIGNATURE L. L. Potter M.D.						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) L. L. POTTER M.D.						22d. ADDRESS LITTLESTOWN, PA.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/29/66		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery			23d. LOCATION (City, town or county) (State) Silver Run, Carroll Co., Md.		
24. FUNERAL DIRECTOR Richard A. Little, Littlestown, PA.						25a. REC'D BY REGISTRAR APR 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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1960

Aug. 25, 1930

U.S. Army, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 26

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Figure 2.1. *Excerpt*

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Silver Lake, California, 1932

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CERTIFICATE OF DEATH

05106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
3 yrs. 7 mos. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21205 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | d. STREET ADDRESS
3203 McElderry Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Henry Middle John Last DIEGELMAN | | | 4. DATE OF DEATH
Month April Day 8 Year 1966 | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
11-19-1894 | | 9. AGE (In years last birthday)
71 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Paperhanger | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 13. FATHER'S NAME
Anthony Diegelman | | | 14. MOTHER'S MAIDEN NAME
Christine Offenstein | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
215-09-4293 | | 17. INFORMANT
Springfield State Hospital Records | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
DUE TO 491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH
mo. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
SEPTICEMIA FROM INFECTED DECUBITUS ULCER | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-9-62 , 19____, to 4-8 , 19 66 , that (I) (we) last saw the deceased alive on 4-8 , 19 66 , and that death occurred at 7^{PM} M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Robert N. Deeb | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4-8-66 | |
| 22c. PHYSICIAN'S NAME (Type)
Robert N. Deeb, M.D. | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/12/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | |
| 23d. LOCATION (City or Town)
Baltimore, Md. | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR
Hoffman Funeral Home Bldg. & Altar | | ADDRESS | | 25a. REC'D BY REGISTRAR
APR 13 1966 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|---|---|--|--|---|--|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 05108 CERTIFICATE OF DEATH 05107 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN 1b
23 yrs. 8 mos. 2 dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
Unknown
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
JOSEPH | | | First
(NMN) | | Middle
DUNN | | Last
April | | 4. DATE OF DEATH
Month
14
Day
19
Year
66 | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8-29-1886 | | 9. AGE (In years last birthday)
79 yrs. | | IF UNDER 1 YEAR
Months
Days
Hours
Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Christopher C. Dunn | | | | | 14. MOTHER'S MAIDEN NAME
Amelia Eser | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Records, Springfield State Hospital | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of stomach
151X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic brain syndrome associated with alcohol intoxication, with psychotic reaction. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
months | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Springfield State Hospital | | (County)
Sykesville
(State)
Maryland | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-12-42 , 19 19 , to 4-14-66 , 19 19 , that (I) (we) last saw the deceased alive on 4-14-66 , 19 19 , and that death occurred at 9:00 A.M. , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Dr. Antonius Glahn | | | | | 22b. DATE SIGNED
4-14-66 | | 22c. PHYSICIAN'S NAME (Type)
Antonius Glahn, M.D. | | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland 21784 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
4/16/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | | 23d. LOCATION (City, town or county)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202 | | | | | 25a. REC'D BY REGISTRAR
APR 18 1966 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | |

15105

GENERAL INVESTIGATION

15105

APR 18 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

05109

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G376 4/26/66 mh

CERTIFICATE OF DEATH

05108

| | | | | | | | | | | | |
|---|----------------------------------|---|---------------------------------------|---|---------------------------------------|---|---|---|---|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN 1b
1 mo. 2 dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
No fixed address
d. STREET ADDRESS
No fixed address
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First
JOSEPH
Middle
(NMN)
Last
ETON | | 4. DATE OF DEATH
Month
April
Day
9
Year
19 66 | | | | | | | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-18-1899 | 9. AGE (In years last birthday)
66 89 yrs. | IF UNDER 1 YEAR
Months
6 | IF UNDER 24 HRS.
Days
19
Hours
66
Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY
Unknown | | 11. BIRTHPLACE (County & State, or foreign country)
Massachusetts | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
yes 1917-1919 | | | 16. SOCIAL SECURITY NO.
Unknown | 17. INFORMANT
Records, Springfield State Hospital
Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO (b) Arteriosclerotic Cardiovascular Disease
DUE TO (c) Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
mo. | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
0021 Pulmonary Tuberculosis | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 3-7-66 , 19 66 , to 4-9 , 19 66 that (I) (we) last saw the deceased alive on 4-9 , 19 66 and that death occurred at 7:30 AM , from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Robert M. Deeb M.D. | | | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
4-9-66 | |
| 22c. PHYSICIAN'S NAME (Type) Robert M. Deeb, M.D. | | | | | | | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland 21784 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR
Frank H. Deeb, Sykesville, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |
| DATE APR 13 1966 | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05110 | | | | | | | | | | 05109 | |
|--|--|----------------------------------|--|--|--|---------------------------------------|---|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>CARROLL COUNTY</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>43 JOHN STREET</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>
d. STREET ADDRESS <u>43 JOHN STREET</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>ROY CHARLES GAMBER</u> | | | 4. DATE OF DEATH <u>APRIL 15</u> 19 <u>66</u> | | | | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>AUG. 19, 1893</u> | | 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>QUARTER MASTER - K.E.W. ADMINISTRATIVE</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL COUNTY</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>RUBIN G. GAMBER</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>MARY C. HARRIS</u> | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW I</u> | | | 16. SOCIAL SECURITY NO. <u>213-05-1514 A</u> | | 17. INFORMANT <u>WIFE MRS ROY C. GAMBER</u> Address <u>43 JOHN ST. WESTMINSTER, MD</u> | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>442x Congestive heart failure, acute.</u>
DUE TO (b) <u>Cardiovascular atherosclerosis &</u>
DUE TO (c) <u>Renal nephrosclerosis & systemia</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>30 months.</u>
<u>few years.</u>
<u>one year</u> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2</u> , 19 <u>66</u> , to <u>4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/14</u> 19 <u>66</u> , and that death occurred at <u>5</u> AM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>William R. O'Rourke</u> M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED <u>4/15/66</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>WILLIAM R. O'ROURKE</u> | | | | | 22d. ADDRESS <u>150 W. MAIN ST. WESTMINSTER, MD</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>4/18/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL'S CEMETERY</u> | | | 23d. LOCATION (City, town or county) (State) <u>ARCADIA MD.</u> | | | | |
| 24. FUNERAL DIRECTOR <u>James G. Saffell Jr.</u> ADDRESS <u>WESTMINSTER, MD.</u> | | | | | 25a. REC'D BY REGISTRAR <u>APR 18 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | |

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CHARLES CAMERON
133 MAIN STREET
WESTPORTER
133 MAIN STREET

KEY CHARLES CAMERON
APRIL 18 1966

WESTPORTER
APRIL 18 1966

WESTPORTER
APRIL 18 1966

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APRIL 18 1966

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APRIL 18 1966

WESTPORTER
APRIL 18 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and many event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

05111

05110

| | | | | | |
|---|----------------------------------|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN lb
6yrs. 6mos. 12dys. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | d. STREET ADDRESS
5905 Kavon Avenue | |
| 3. NAME OF DECEASED
(Type or print)
AUGUSTA | | First
(NMN) | | Middle
GOLDERMAN | |
| 4. DATE OF DEATH
APRIL 14 | | Month
19 | | Day
66 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED
<input type="checkbox"/> NEVER MARRIED
<input checked="" type="checkbox"/> WIDOWED
<input type="checkbox"/> DIVORCED | 8. DATE OF BIRTH
2-1-1874 | 9. AGE (In years lost birthday)
92 yrs. | 10. IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Unk. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
John H. Lenhart | | 14. MOTHER'S MAIDEN NAME
Unk. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
Unk. | | 17. INFORMANT
Records, Springfield State Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
DUE TO
(b) Generalized arteriosclerosis
DUE TO
(c) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction | | | | | INTERVAL BETWEEN ONSET AND DEATH
Years
Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
CBS assoc. with cerebral arteriosclerosis, with psychotic reaction | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 10-2-59 , 19 to 4-14-66 , 19, that (I) (we) last saw the deceased alive on 4-14-66 , 19, and that death occurred at 11:50 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Agustin del Campo</i> | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
4-14-66 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M. D. | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/16/1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | 24. FUNERAL DIRECTOR
Wm. J. Tribner & Son | | | |
| 25a. REC'D BY REGISTRAR
APR 19 1966 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

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• *Journal of the American Medical Association*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|-------------------------------------|--|---|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 05112 | | | | | | | | | | | |
| 05111 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. CDUNTY CARROLL MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Maryland b. COUNTY CARROLL | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Sykesville | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural - Sykesville 06-1 | | | | | |
| c. LENGTH OF STAY IN 1b
3 Weeks | | | | | | d. STREET ADDRESS
Gaither Manor Apt's. | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Pollen Nursing Home | | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) ROBERT N. HAMMOND | | | | | | 4. DATE OF DEATH APRIL 18 1966 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5-9-1909 | | 9. AGE (In years last birthday) 56 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Social Security | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Wm Lee Hammond | | | | | | 14. MOTHER'S MAIDEN NAME
Josephine Forsythe | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO.
WW II | | 17. INFORMANT
MR. Arthur Hammond - Ellicott City, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Suffocation
161X DUE TO Intratracheal hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Terminal Ca of Larynx
(b) 1 year.
(c) 1 year. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
20 minutes
20 minutes
1 year. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
none | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 3.24.1964 to 4.18.1966 , that (I) (we) last saw the deceased alive on 4.18.1966 , and that death occurred at 11 AM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Sani Okutman | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4.19.66 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Sani Okutman | | | | | | 22d. ADDRESS
Sykesville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
4-21-66 | | 23c. NAME OF CEMETERY OR CREMATORY
OAK Grove Cemetery | | 23d. LOCATION (City, town or county) (State)
Howard Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR
Harry W. Haight | | | | | | ADDRESS
Sykesville, Md. | | 25a. REC'D BY REGISTRAR
APR 25 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles J. J... | |

2001 02 17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|----------------------------------|---|---|--|--------------------------------------|--|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 05112 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <i>Carroll</i> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Manchester</i> | | | | | c. LENGTH OF STAY IN 1b
<i>41 yrs.</i> | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | d. STREET ADDRESS
<i>14 New Street</i> | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>Grace</i> Middle <i>Rebecca</i> Last <i>Heiston</i> | | | | | 4. DATE OF DEATH
Month <i>April</i> Day <i>3</i> Year <i>1966</i> | | | | | | |
| 5. SEX
<i>Female</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>3/15/1886</i> | | 9. AGE (in years last birthday)
<i>80</i> yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | |
| 13. FATHER'S NAME
<i>Columbus Nicholas Hensley</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Columbia Francis</i> | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>no</i> | | | | | 16. SOCIAL SECURITY NO.
<i>215-074633</i> | | 17. INFORMANT
<i>Christine Gough</i> | | | Address
<i>Manchester, Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>
4201
DUE TO <i>Arteriosclerotic Cardio Vascular Disease</i>
DUE TO <i>Disease</i>
DUE TO
INTERVAL BETWEEN ONSET AND DEATH
<i>2 hr</i>
<i>8 yrs</i> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>Cerebral Arteriosclerosis</i> | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
<i>19</i> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (II) (this hospital) attended the deceased from <i>Nov</i> , 1947, to <i>4/3</i> , 1966, that (I) (we) last saw the deceased alive on <i>4/1</i> , 1966, and that death occurred at <i>8:30 P.</i> from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<i>W. H. Foard</i> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<i>4/4/66</i> | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<i>W. H. Foard M.D.</i> | | | | | 22d. ADDRESS
<i>Manchester, Md.</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 23b. DATE THEREOF
<i>4/6/66</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Immanuel Cemetery</i> | | 23d. LOCATION (City, town or county) (State)
<i>Manchester Md.</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>Tipton-Eline Fun. Home, Hampstead, Md.</i> | | | | | 25a. REC'D BY REGISTRAR
<i>APR 7 1966</i> | | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Judge</i> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05113

05114

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Taneytown</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>P.O. Route # 1M</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) First <u>Birdie</u> Middle <u>Belle</u> Last <u>Hess</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1966</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>December 28, 1890</u> | |
| 9. AGE (In years last birthday) yrs. <u>75</u> | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housework</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Richard Hess</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Hahn</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service)
<u>None</u> | | 17. INFORMANT
Address
<u>Mrs. Ralph Shipley R#1M Taneytown, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH <u>8 Hrs.</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>4/5/66</u> 19 to <u>4/6/66</u> 19, that I last saw the deceased alive on <u>4/5/66</u> 19, and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE <u>M.E. Robertson</u> M.D. <u>New Windsor, Md. 4/6/66</u>
PHYSICIAN'S NAME (Type) <u>M.E. Robertson</u> <u>New Windsor, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>4/8/66</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Lutheran Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Taneytown, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>C.O. Fuss & Son</u>
Taneytown, Maryland | | | | 24a. REC'D BY REGISTRAR
<u>APR 7 1966</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

CERTIFICATE OF DEATH

| | | | |
|---------------------------------------|--|--------------------------------|--|
| PLACE OF DEATH
HOME | | SEX
FEMALE | |
| DATE OF DEATH
APRIL 10 1961 | | AGE
78 | |
| PLACE OF BIRTH
BALTIMORE, MARYLAND | | RACE
WHITE | |
| OCCUPATION
RETIRED | | MARITAL STATUS
MARRIED | |
| CAUSE OF DEATH
HEART DISEASE | | MANNER OF DEATH
NATURAL | |
| SIGNATURE OF DECEASED
(None) | | SIGNATURE OF WITNESS
(None) | |
| SIGNATURE OF PHYSICIAN
(None) | | SIGNATURE OF CORONER
(None) | |
| SIGNATURE OF REGISTRAR
(None) | | SIGNATURE OF CLERK
(None) | |

CERTIFICATE OF DEATH

05115

05114

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN b.
2 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Pullen Nursing Home | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore 21
d. STREET ADDRESS
1724 Glen Curtis Rd.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Luther E. Holt | | 4. DATE OF DEATH
Month Day Year
April 17, 1966 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 6, 1892 |
| 9. AGE (In years last birthday)
74 yrs. | | 10. IF UNDER 1 YEAR
Months Days
74 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sanitation Dept. | | 10b. KIND OF BUSINESS OR INDUSTRY
Martin Co. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Frederick Co., Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles Holt | | 14. MOTHER'S MAIDEN NAME
Lucinda Stottlemeyer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
Yes WW 1 | | 16. SOCIAL SECURITY NO.
213-18-0658 | |
| 17. INFORMANT
Mr. Markel E. Holt | | Address
Balto. 21, Md. 23 Ridgemoor Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diabetes, severe; Caronary thrombosis;
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Cardiac failure; Pneumonia;
(a), stating the underlying cause last. DUE TO
(c) Cerebral vascular accident. | | INTERVAL BETWEEN ONSET AND DEATH
1965 through April 17, 1966 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 2Da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1965 , 19... to April 17 , 1966, that (I) (we) last saw the deceased alive on April 17 , 1966, and that death occurred at 6:35 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Howard E. Hall | | 22b. DATE SIGNED
April 18, 1966 | |
| 22c. PHYSICIAN'S NAME (Type)
Howard E. Hall, M.D. | | 22d. ADDRESS
Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
4/20/1966 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Hope Cemetery | 23d. LOCATION (City, town or county) (State)
Frederick Co., Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE
C. M. Waltz | | 25a. BY REGISTRAR
APR 20 1966 | |

05119

UNITED STATES OF AMERICA

05119

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 05-11-93 BY 60322 UCBAW/SJS/STP

APR 20 1952

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05116

CERTIFICATE OF DEATH

05115

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | |
| c. LENGTH OF STAY IN Tb <u>30 yrs</u> | | d. STREET ADDRESS <u>161 W. Main St.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>WALTER FRANKLIN HUTCHINS</u> | | 4. DATE OF DEATH <u>APRIL 9 1966</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 2, 1885</u> |
| 9. AGE (In years lost birthday) <u>81</u> yrs. | | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired florist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale & Retail</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Howard Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Hutchins</u> | | 14. MOTHER'S MAIDEN NAME <u>Abbie Webb</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-05-8819</u> | |
| 17. INFORMANT <u>Mrs Walter F. Hutchins</u> | | Address <u>Same</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO
(c) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 6, 1966</u> , to <u>April 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 9, 1966</u> , and that death occurred at <u>2:45</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John S. Harshey</u> | | 22b. DATE SIGNED <u>4/9/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u> | | 22d. ADDRESS <u>8 Archer St. Westminster, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>4/12/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u> | 23d. LOCATION (City or Town) (County) (State) <u>Mt. Airy, Md.</u> |
| 24. FUNERAL DIRECTOR <u>J. S. Myers, Jr. Westminster, Md.</u> | | 25a. REC'D BY REGISTRAR <u>APR 12 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05113

02116



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FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

101 Film G375 4710/65-100
M
05117
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
05116

| | | | |
|---|---------------------------|---|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
6 yrs./25 das | |
| c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Silver Spring | | 15-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Springfield State Hospital | | d. STREET ADDRESS
Norwood Road, Rt. 1 | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Geraldine Marie JONES | | 4. DATE OF DEATH
Month Day Year
April 2, 19 66 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-10-1937 |
| 9. AGE (In years last birthday)
28 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | 10b. KIND OF BUSINESS OR INDUSTRY
— | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Robert F. Jones | | 14. MOTHER'S MAIDEN NAME
Ida Marie Spreen | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Springfield State Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia due to occlusion of larynx by piece of frankfurter.</u>
9217
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(b) <u>Pulmonary edema.</u>
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
CBS assoc. with other intracranial infection other than Syphilis without qualifying phrase. Encephalitis in childhood. | | INTERVAL BETWEEN ONSET AND DEATH
mins.
mins. | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
While receiving noon meal, piece of frankfurter became lodged in trachea. | |
| 20c. TIME OF INJURY Month, Day, Year
Hour Min. p.m. 4/2 19 66 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hospital | | 20f. (City or town) (County) (State)
Sykesville Carroll Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
W. Glenn Speicher | | 22. DATE SIGNED
4-2-66 | |
| EXAMINER'S NAME (Type)
W. Glenn Speicher, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
135 E. Main St. Westminster, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-5-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Memorial Park Cemetery | | 23d. LOCATION (City, town or county) (State)
Lima, Ohio | |
| 24. FUNERAL DIRECTOR
Harry W. Haight | | 25a. REC'D BY REGISTRAR
APR 6 1966 | |
| ADDRESS
Sykesville, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

01110

WORLD LEADERS CENTRAL OF DEATH

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APR 11 1955

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05118

05117

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
CARROLL
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
WESTMINSTER | | c. LENGTH OF STAY IN 1b
8 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Carroll County General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Alverta May Keller | | 4. DATE OF DEATH
Month Day Year
4 12 1966 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 1, 1883 |
| 9. AGE (In years last birthday)
82 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min.
12 19 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Steven G. Lloyd | | 14. MOTHER'S MAIDEN NAME
unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Gilbert Keller, Upperco, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR INSUFFICIENCY
DUE TO (b) CEREBRAL ARTERIO SCLEROSIS
DUE TO (c) YEARS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
① ARTERIOSCLEROTIC HEART DISEASE-DECOMPENSATED ③ BRONCHOPNEUMONIA | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
4 DAYS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/2, 1966 to 4/12, 1966 , that (I) (we) last saw the deceased alive on 4/12, 1966 , and that death occurred at 6:35 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Vincent J. Krowc | | 22b. DATE SIGNED
4/12/66 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/15/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Mem. Gardens | | 23d. LOCATION (City or Town) (County) (State)
Finkeburg, Md. | |
| 24. FUNERAL DIRECTOR
Tipton-Eline Funeral Home, Hampstead Md. | | 25a. REC'D BY REGISTRAR
APR 18 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

51150

Cerebral Vascular Insufficiency with
Cerebral Hemorrhages

① Atmospheric pressure (atmospheric pressure) ② Atmospheric pressure

APR 1 2 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|-------------------------------|---|--|---|---|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 05119 CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Carrace</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>
c. LENGTH OF STAY IN 1b <u>23 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Montg.</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs Md</u>
d. STREET ADDRESS <u>10507 Lester Street</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Miles</u> First <u>(n.m.n)</u> Middle <u>Keller</u> Last | | | | | 4. DATE OF DEATH
Month <u>4</u> Day <u>9</u> Year <u>1966</u> | | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6/1/86</u> | | 9. AGE (In years last birthday) <u>79</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>agriculture</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Jacob Keller</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Hettie Hertzog</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>None</u> | | | | | 16. SOCIAL SECURITY NO. <u>205-30-2532</u> | | 17. INFORMANT <u>Springfield Hospital</u>
<u>Records Sykesville Md</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Terminal Uremia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Heart disease</u>
DUE TO (c) <u>General Arteriosclerosis</u> | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS senile brain disease with psychotic reaction</u> | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that <u>1</u> (this hospital) attended the deceased from <u>3-18-</u> , 19 <u>66</u> , to <u>4-9</u> , 19 <u>66</u> , that <u>1</u> (we) last saw the deceased alive on <u>4-9</u> , 19 <u>66</u> , and that death occurred at <u>7:50</u> PM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Suha Ozgun</u> | | | | | | | | 22b. DATE SIGNED <u>4-10-66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>SUHA OZGUN</u> | | | | | 22d. ADDRESS <u>Springfield State Hospital</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>13 April 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Airy Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Lancaster Co., Penna.</u> | | |
| 24. FUNERAL DIRECTOR <u>Thomas & Humphrey Inc</u> | | | | | 25a. REC'D BY REGISTRAR <u>APR 13 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

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THE STATE OF CALIFORNIA

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05120

CERTIFICATE OF DEATH

05119

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|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Md.
b. COUNTY
Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Westminster | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Carroll County General Hospt. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Daniel Park Kieffer | | 4. DATE OF DEATH
Month 4 Day 17 Year 1966 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 3, 1886 |
| 9. AGE (In years last birthday) yrs.
79 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Election Board of Baltimore County | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore Co. Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Stephen Kieffer | | 14. MOTHER'S MAIDEN NAME
Ruth Loflin | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-12-6502 | |
| 17. INFORMANT
Mrs. Rabeth S. Kieffer | | Address
Reisterstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL ANOXIA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. BRONCHOPNEUMONIA - RUL + RLL
DUE TO
(b) 2 WEEKS
(c) 491X | | | INTERVAL BETWEEN ONSET AND DEATH
4 DAYS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
PULMONARY EMPHYSEMA | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 4/13, 1966 to 4/17, 1966 , that (I) (we) last saw the deceased alive on 4/17, 1966 , and that death occurred at 8:30 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Vincent J. Frown J. | | 22b. DATE SIGNED
4/17/66 | |
| 22c. PHYSICIAN'S NAME (Type)
M.D. | | 22d. ADDRESS
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
4/20/66 | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Grove Cemetery | 23d. LOCATION (City or Town) (County) (State)
Boring, Md. |
| 24. FUNERAL DIRECTOR
J. F. Eline & Sons | | 25. PREPARED BY REGISTRAR
APR 19 1966 | |
| ADDRESS
Reisterstown, Md. | | 25b. PREPARED BY SIGNATURE
J. F. Eline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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WATER TREATMENT PLANT

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APR 14 1968

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05122

05121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middleburg</u>
c. LENGTH OF STAY IN 1b <u>1 year</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brookfield Manor Nursing Home</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor</u>
d. STREET ADDRESS <u>Church Street</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Florence</u> Middle <u>H.</u> Last <u>Lindsay</u> | | | 4. DATE OF DEATH
Month <u>April</u> Day <u>8</u> Year <u>1966</u> | | | | |
| 5. SEX
<u>F</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
<u>July 9, 1873</u> | | | |
| 9. AGE (In years last birthday) <u>92</u> yrs. | | IF UNDER 1 YEAR
Months <u>06</u> Days <u>01</u> | | IF UNDER 24 HRS.
Hours <u>00</u> Min. <u>00</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housekeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | | 13. FATHER'S NAME
<u>Theodore Harman</u> | | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Martha Repp</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | |
| 16. SOCIAL SECURITY NO.
<u>None</u> | | | 17. INFORMANT
<u>Russell Lindsay</u> RFD 5 Westminister, Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arteriosclerotic CVD</u>
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (b) }
(a), stating the underlying cause last. DUE TO (c) } | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. <u>19</u>
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/1/56</u> 19 <u>4/8/66</u> 19 , to <u>4/8/66</u> 19 , that (I) (we) last saw the deceased alive on <u>4/8/66</u> 19 , and that death occurred at <u>1045 P</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>M. E. Robertson</u> | | | | 22b. DATE SIGNED
M.D. <u>APR 12 1966</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>M. E. Robertson</u> | | | | 22d. ADDRESS
<u>New Windsor, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>4/11/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Bethel Cemetery</u> | | | |
| 23d. LOCATION (City, town or county)
<u>New Windsor Rural</u> | | (State)
<u>Md.</u> | | 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Ed Hartley & Sons New Windsor, Md</u> | | | |
| 25a. REC'D BY REGISTRAR
<u>APR 12 1966</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | |

1812

March

England

Carroll

New Windsor

1 year

Middlebury

Church Street

Brookfield and Hurst House

Langley

Thomas

July 9, 1873

W. N.

Windsor

On home

Housekeeper

North Bell

Thomas Brown

Massachusetts

Home

M. E. Robertson

Bethel Cemetery

New Windsor

1873

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(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 05122 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
CARROLL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL - Sykesville
c. LENGTH OF STAY IN b
9 YR. 1 MO. 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Springfield State Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE
d. STREET ADDRESS
5928 SEFTON AVE.
BALTIMORE - 14 MD.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
GEORGE BENJAMIN LUTZ | | | | | 4. DATE OF DEATH
Month Day Year
APRIL 16 1966 | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7-10-93 | | 9. AGE (In years last birthday)
72 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SALES man | | 10b. KIND OF BUSINESS OR INDUSTRY
UNKNOWN | | 11. BIRTHPLACE (County & State, or foreign country)
MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | | |
| 13. FATHER'S NAME
George LUTZ | | | | | 14. MOTHER'S MAIDEN NAME
Rebecca JOHNSON | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
220-18-2623 | | 17. INFORMANT
HOSPITAL RECORD - | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4221 Cardiac Failure
DUE TO (b) Atherosclerotic Cardiovascular Disease
DUE TO (c)
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 MO 4 YR. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-15, 1957, to 4-16, 1966, that (I) (we) last saw the deceased alive on 4-16, 1966, and that death occurred at 4 PM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
[Signature]
22c. PHYSICIAN'S NAME (Type)
ROBERT M. DEEB | | | | | 22b. DATE SIGNED
4-16-66
22d. ADDRESS
S.S. Hospital - Sykesville, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/19/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Wm. Cook-Brooks Inc. 1217 St. Paul St. | | | | | 25a. REC'D BY REGISTRAR
DATE
APR 19 1966 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

65188

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICS
BUREAU OF VITAL STATISTICS

DEATH CERTIFICATE

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

EDUCATION

RELIGION

APR 19 1900

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05124

CERTIFICATE OF DEATH

05123

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
o. COUNTY
Carroll
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE
Maryland
b. COUNTY
Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN Is
42yrs.5mos.25dys.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | d. STREET ADDRESS
(unknown) | |
| 3. NAME OF DECEASED
(Type or print) LENA (MADELINE)
First Middle Last | | 4. DATE OF DEATH
APRIL 6 19 66
Month Day Year | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-11-92 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
- | 9. AGE (In years last birthday) yrs.
73 |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
(Unknown) | | 14. MOTHER'S MAIDEN NAME
(Unknown) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Records, Springfield State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) CORONARY ARTERIOSCLEROSIS
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
minutes
years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Schizophrenic reaction, paranoid type. | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (it) (this hospital) attended the deceased from 10-11 , 19 66 , that (it) (we) last saw the deceased alive on 4-6 19 66 , and that death occurred at 12:30 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Ilse Kamm | | 22b. DATE SIGNED
4-6-66 | |
| 22c. PHYSICIAN'S NAME (Type)
Ilse Kamm, M.D. | | 22d. ADDRESS
Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-11-1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt. Carmel | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Lilly & Zeiler Inc.. | | 25a. REC'D BY REGISTRAR
APR 11 1966 | |
| ADDRESS
190107 Eastern Ave. | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Little, Esther M., 1907 Boston, W.

4-11-19

St. James

St. James, W.

St. James, W.

W.

Orthopedic Dept. Inc., Portland, Me.

None

Recorder, Portland, Me. Hospital

(Unknown)

Unknown

Nonexistent

(Part) and

11-11-19

Records -

St. James (Good)

(Good)

St. James

St. James -

(Unknown)

St. James

St. James, W.

St. James

St. James

St. James

St. James

St. James

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

(M)

05125

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05124

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Sykesville | | | | c. LENGTH OF STAY IN 1b
3yrs.7mos.17dys. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Springfield State Hospital | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Linthicum Heights | | | |
| d. STREET ADDRESS
202 Homewood Road | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First BLANCHE Middle CLARICE Last MASSEY | | | | 4. DATE OF DEATH
Month APRIL Day 14 Year 1966 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11-11-02 | |
| 9. AGE (In years last birthday)
63 yrs. | | IF UNDER 1 YEAR
Months 63 Days 0 Hours 0 Min. 0 | | IF UNDER 24 HRS.
Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Waitress/housekeeper | | | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (County & State, or foreign country)
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Roland Kelly | | | | 14. MOTHER'S MAIDEN NAME
Adeline Shea | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
(none) | | 17. INFORMANT
Records, Springfield State Hospital | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
4201 DUE TO Arteriosclerotic coronary disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) years
DUE TO (c) minutes | | | | INTERVAL BETWEEN ONSET AND DEATH
minutes | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Brain Syndrome associated with presenile brain disease, without qualifying phrase | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (H) (this hospital) attended the deceased from 8-27 , 19 62 , to 4-14 , 19 66 , that (H) (we) last saw the deceased alive on 4-14 , 19 66 , and that death occurred at 9:50A from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Ilse Kamm, M.D. | | | | 22b. DATE SIGNED
April 14, 1966 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Ilse Kamm, M.D. | | | | 22d. ADDRESS
Sykesville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
4-16-66 | | 23c. NAME OF CEMETERY OR CREMATORY
St Stephens | |
| 23d. LOCATION (City, town or county) (State)
Delmar, Del. | | | | | | | |
| 24. FUNERAL DIRECTOR
Charles H. Gamm - Delmar, Del | | | | 25a. REC'D BY REGISTRAR
APR 15 1966 | | | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

1950

1950

Department of Defense

Section 1

Mr. J. Edgar Hoover

Washington, D.C.

Dear Mr. Hoover:

Enclosed for you are

three copies of a

report dated

March 1, 1950

by the

Department of Defense

concerning

the

subject

of the

Department of Defense

is being

forwarded

to you for your information.

Sincerely,

John F. Kennedy

President

John F. Kennedy

President

John F. Kennedy

President

President

President

1950

05126

CERTIFICATE OF DEATH

05125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | c. LENGTH OF STAY IN 1b <u>4 days</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timberburg RD #1</u> | | d. STREET ADDRESS <u>Sullivan Trader Court</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>EDWARD WESLEY McELWAIN, SR.</u> | | 4. DATE OF DEATH <u>April 2 19 66</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 10, 1923</u> 42 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Servant work WMC College</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Kittanning Pa. U.S.A.</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY | |
| 13. FATHER'S NAME <u>Hastings McElwain</u> | | 14. MOTHER'S MAIDEN NAME <u>Estel Harter</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW II</u> | | 16. SOCIAL SECURITY NO. <u>205-12-4228</u> | |
| 17. INFORMANT <u>Mrs. Thelma S. McElwain</u> | | Address <u>Timberburg Rd. RD #1</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>
163X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Carcinoma of the lung</u>
(c) <u>Carcinoma of the lung</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Mar 30</u> , 19 <u>66</u> , to <u>April 2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 2</u> , 19 <u>66</u> , and that death occurred at <u>11:35</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John S. Harshey</u> | | 22b. DATE SIGNED <u>4/2/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u> | | 22d. ADDRESS <u>Garcho St. Westminster, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>4/6/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lane Haven Burial</u> | 23d. LOCATION (City or Town) (County) (State) <u>Kittanning Pa.</u> |
| 24. FUNERAL DIRECTOR <u>J. S. Impres J. Westminster Md</u> | | 25a. REC'D BY REGISTRAR <u>APR 6 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

112152

CERTIFICATE OF DEATH

0214

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
BOSTON, MASSACHUSETTS

| | | | |
|-------------------------|--|-----------------------------|--|
| Name of Deceased | | Date of Birth | |
| Sex | | Race | |
| Marital Status | | Place of Birth | |
| Cause of Death | | Date of Death | |
| Place of Death | | Signature of Registrar | |
| Signature of Physician | | Signature of Coroner | |
| Signature of Undertaker | | Signature of Burial Officer | |
| Signature of Witness | | Signature of Minister | |
| Signature of Family | | Signature of Friends | |
| Signature of Church | | Signature of Community | |
| Signature of State | | Signature of Nation | |

RECEIVED
BUREAU OF VITAL RECORDS
BOSTON, MASSACHUSETTS
JAN 10 1914

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05127

CERTIFICATE OF DEATH

05126

| | | | | | |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll
MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural--Sykesville | | c. LENGTH OF STAY IN Tb
6mo. 11days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | d. STREET ADDRESS
2806 Roselawn Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Laura Middle Virginia Last Mettee | | | 4. DATE OF DEATH
Month 4 Day 12 Year 19 66 | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
03/12/80 | 9. AGE (In years birthday) yrs.
86 | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 13. FATHER'S NAME
Richard Tydings | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | | 16. SOCIAL SECURITY NO.
218-46-2460 | | |
| 17. INFORMANT
Springfield Hospital records-Sykesville | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Uremia
DUE TO
(c) Arteriosclerotic cardiovascular disease | | | | | INTERVAL BETWEEN ONSET AND DEATH
days
days
years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Chronic brain syndrome with senile brain disease without qualifying phrase. | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (this hospital) attended the deceased from 10/1/65 , to 4/12/66 , that (we) last saw the deceased alive on 4/12/66 , and that death occurred at 8:30 P.M. from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Edmee J. Reeves, M. D. | | | 22b. DATE SIGNED
4/13/66 | | |
| 22c. PHYSICIAN'S NAME (Type)
Edmee J. Reeves, M. D. | | | 22d. ADDRESS
Springfield State Hospital Sykesville, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
April 16, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Oaklawn Cemetery | |
| | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
E. E. LOWELL LEMMON | | ADDRESS
4611 Park Heights Ave. | | 25a. REC'D BY REGISTRAR
APR 18 1966 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|----------------------------------|---|---|---|---|---|--|--|---|--|
| 05128 | | | | | 05127 | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Carroll | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allego | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural-Sykesville | | | c. LENGTH OF STAY IN 1b
9 Days | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Springfield State Hospital | | | | | d. STREET ADDRESS
12 Harrison Street | | | | | | |
| 3. NAME OF DECEASED
(Type or print) John Nicholas Morrissey | | | | | 4. DATE OF DEATH
Month 4 Day 30 Year 66 | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9-25-94 | | 9. AGE (In years birthday) 71 yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Owner & Prop. | | | 10b. KIND OF BUSINESS OR INDUSTRY
Antique business | | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland Cumberland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Michael Morrissey | | | | | 14. MOTHER'S MAIDEN NAME
Annie Farlong | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, Yes unknown) (If so, give year or dates of service)
W. W. # 1 | | | 16. SOCIAL SECURITY NO.
220-10-7120 | | 17. INFORMANT
Springfield Hospital Records | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4221 Branchopneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (b) Arterio-sclerotic cardiovascular disease
DUE TO (c) Generalized arterio-sclerosis. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Brain Syndrome of Unknown Cause | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4-21 , 19 66 , to 4-30 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4-30 , 19 66 , and that death occurred at 1 A. , from the causes and on the date stated above. | | | | | | | | | | 22b. DATE SIGNED | |
| 22a. SIGNATURE
R.G. Lajonchere MD | | | | | 22c. PHYSICIAN'S NAME (Type) R.G. Lajonchere | | | | | 22d. ADDRESS Springfield State Hospital Sykesville Maryland. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
5/3/66 | | 23c. NAME OF CEMETERY OR CREMATORY
SS. Peter & Paul Cem. | | | 23d. LOCATION (City, town or county) (State)
Cumberland Maryland | | | |
| 24. FUNERAL DIRECTOR
H. Wayne George | | | | | 25a. REC'D BY REGISTRAR
MAY 3 1966 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|--------------------------------------|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural--Sykesville
c. LENGTH OF STAY IN 1b
1yr. 9days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Springfield State Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Washington
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Gapland
d. STREET ADDRESS
--
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
Beulah | | First
Virginia | | Middle
Moss | | Last
4 | | 4. DATE OF DEATH
Month
4
Day
5
Year
1966 | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/21/92 | | 9. AGE (In years last birthday)
73 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
James Cochran | | | | | 14. MOTHER'S MAIDEN NAME
Ida Reeder | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Springfield Hospital records, Sykesville
Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
4200
DUE TO Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Branchopneumonia
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic brain syndrome with circulatory disturbance other than cerebral arteriosclerosis (arteriosclerosis & hypertensive cardiovascular disease) with psychotic reaction. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
months
years
days | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of Item 18.)
cardiovascular disease | | | | | | | |
| 21c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 21d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 21f. (City or town) (County) (State) | | | |
| 21. I certify that the (this hospital) attended the deceased from 3/26/1965 to 4/5/1966 , that we last saw the deceased alive on 4/5/1966 , and that death occurred at 2:00 p.m. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Naci N. Buyukunsal | | | | | 22b. DATE SIGNED
4/5/66 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Naci N. Buyukunsal, M.D. | | | | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-7-66 | | 23c. NAME OF CEMETERY OR CREMATORY
Locust Grove Cemetery | | | 23d. LOCATION (City, town or county) (State)
Locust Grove, Md. | | |
| 24. FUNERAL DIRECTOR
Wm. F. Balt. ... | | | | | 25a. REC'D BY REGISTRAR
APR 11 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

Carroll

Dr. J. H. H. H. H.

Dr. J. H. H. H. H.

Hughes

White

Hornum

James Cooper

No

Case

Dr. J. H. H. H. H.

Brochopneumonia
Heart Failure
Hypertension

Heart Failure

Chronic brain syndrome with or without disturbance of other than cerebral metabolism (arteriosclerosis & hypertension) or cardiovascular disease with psychotic reaction.

Dr. J. H. H. H. H.

Dr. J. H. H. H. H.

Dr. J. H. H. H. H.

Dr. J. H. H. H. H.

CERTIFICATE OF DEATH

05129

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Middleburg
c. LENGTH OF STAY IN 1b
4 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Brookfield Manor Nursing Home | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE
Maryland
b. COUNTY
Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Taneytown
d. STREET ADDRESS
06-1
e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Grace Motter | | 4. DATE OF DEATH
Month Day Year
April 2, 1966 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 4, 1882 |
| 9. AGE (In years last birthday)
83 yrs. | | 10. IF UNDER 1 YEAR
Months Days | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | 11. BIRTHPLACE (County & State, or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY
U.S.A. | | 13. FATHER'S NAME
Thomas Baker | |
| 14. MOTHER'S MAIDEN NAME
Elizabeth Shriner | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
Mr. Clarence J. Motter, Taneytown, Md. | | 17. INFORMANT
Mr. Clarence J. Motter, Taneytown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
331X
DUE TO (b) Cerebral arteriosclerosis and thrombosis
DUE TO (c) 331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m.
19 | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not White <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 3/18/66 , 19 66 , to 4/2/66 , 19 66 , that (I) (we) last saw the deceased alive on 4/2/66 , 19 66 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
J. H. Caricofe
M.D. | | 22b. DATE SIGNED
4/2/66 | |
| 22c. PHYSICIAN'S NAME (Type)
J. H. Caricofe | | 22d. ADDRESS
Union Bridge, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
April 5, 1966 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. View Cemetery | 23d. LOCATION (City, town or county) (State)
Emmitsburg, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John H. Skiles
ADDRESS
C.O. Fuss & Son, Taneytown, Md. | | 25a. REC'D BY REGISTRAR
APR 5 1966
25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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— *Continued*

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05130

05131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY - | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural--Sykesville | | c. LENGTH OF STAY IN 1b
10y. 11m. 6d. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | d. STREET ADDRESS
311 Cathedral Street | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Margaret Middle Dolores Last Murray | | 4. DATE OF DEATH
Month 4 Day 24 Year 19 66 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/15/82 |
| 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Registered nurse | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Daniel A. L. Murray | | 14. MOTHER'S MAIDEN NAME
Anna Cecilia Ward | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
unknown | |
| 17. INFORMANT
Springfield Hospital records--Sykesville | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure
170X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma breast metastasis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis with psychotic reaction. | | INTERVAL BETWEEN ONSET AND DEATH
months
years | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from 5/18/ 19 55 to 4/24/ 19 66 that (X) (we) last saw the deceased alive on 4/24/ 19 66 , and that death occurred at 1:45 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Naci N. Buyukunsal</i> | | 22b. DATE SIGNED
4/24/66 | |
| 22c. PHYSICIAN'S NAME (Type)
Naci N. Buyukunsal, M. D. | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
4-27-66 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Harry Haight | | 25a. REC'D BY REGISTRAR
Sykesville, Md. | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | DATE
APR 29 1966 | |

10130

10131

UNITED STATES OF AMERICA

Married

Married

101. 111. 04. Baltimore

101. 111. 04. Baltimore

111. 111. 04. Baltimore

111. 111. 04. Baltimore

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111. 111. 04. Baltimore

111. 111. 04. Baltimore

Chronic brain syndrome associated with circulatory disturbance,
with cerebral arteriosclerosis with systemic reaction.

111. 111. 04. Baltimore

111. 111. 04. Baltimore

111. 111. 04. Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|-------------------------------|--|--|--|--|--|--|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville
c. LENGTH OF STAY IN 1b 0y 11m 8d
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown 21740
d. STREET ADDRESS 197 W. Wilson Boulevard
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) PRESTON
First Elmer Middle ELMIRE Last MYERS | | | | | | 4. DATE OF DEATH April 28 1966
Month April Day 28 Year 1966 | | | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-3-1881 | | 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (County & State, or foreign country) Cearioss Wash Co Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME William Myers | | | | | | 14. MOTHER'S MAIDEN NAME Mary A. Sprinkle | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none | | | | 16. SOCIAL SECURITY NO. 217-12-1840 | | 17. INFORMANT Hospital Records | | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
491X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 days | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) -- | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. -- p.m. -- 19 65 | | | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- | | 20f. (City or town) -- (County) -- (State) -- | | | |
| 21. I certify that he (this hospital) attended the deceased from 5-20- , 1965 , to 4-28 , 1966 , that he (we) last saw the deceased alive on 4/28 , 1966 , and that death occurred at 2:45 PM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Sam P. Wise III | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED 4/28/66 | | |
| 22c. PHYSICIAN'S NAME (Type) Sam P. Wise III | | | | | | 22d. ADDRESS Springfield State Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 5/1/66 | | 23c. NAME OF CEMETERY OR CREMATORY Dunkard Cemetery | | | 23d. LOCATION (City, town or county) (State) Broadfording Wash Co Md | | |
| 24. FUNERAL DIRECTOR Hagerstown ADDRESS Md. | | | | | | 25. REC'D BY REGISTRAR MAY 2 1966 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

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05133

CERTIFICATE OF DEATH

05132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

| | | | | | | | |
|---|-------------------------------|--|-------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | c. LENGTH OF STAY IN 1b) <u>5 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospital</u> | | | | d. STREET ADDRESS <u>Mineral Hill Road</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>FRANK NICKOLAS</u> | | | | 4. DATE OF DEATH <u>4</u> Month <u>28</u> Day <u>19</u> Year <u>66</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 2, 1883</u> | | 9. AGE (In years last birthday) <u>82</u> yrs. | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Albert Nickolas</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Rauterback</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mr. Michael Nickolas</u> Address <u>Sykesville, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>DIAPHRAGMATIC MYOCARDIAL INFARCT</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>YEARS</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4/23</u> , 19 <u>66</u> , to <u>4/28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/28</u> 19 <u>66</u> , and that death occurred at <u>4:32</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Vincent J. Ficocci</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>4/28/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>VINCENT J. FICOCCHI</u> | | | | 22d. ADDRESS <u>Westminster, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>4-30-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Park View Memorial</u> | | 23d. LOCATION (City or town) (County) (State) <u>Sykesville Carroll, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Arthur H. Haight</u> ADDRESS <u>Sykesville, Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>MAY 3 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

56130

STATE OF NEW YORK

1871

4-8-10 1000 P. M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05134 CERTIFICATE OF DEATH 05133

| | | | | | | | |
|---|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>CARROLL</u>
<u>Montgomery</u> County | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Woodbine</u> | | c. LENGTH OF STAY IN b
<u>2 weeks</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | d. STREET ADDRESS
<u>2109 Hanover Street</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Woodbine/ Nubshing/ Home Miller's Conv. Home</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>Thomas Brewster Penicks</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>April 17 19 66</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>March 29, 1885</u> | | 9. AGE (In years last birthday)
<u>81</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Ret. Asst. Station Master</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Washington Terminal Co.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Washington, D. C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Thomas B. Penicks</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Jarret Laurie</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>David C. Penicks</u> Address <u>539 Gladstone Blvd. Kansas City, Mo.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive coronary thrombosis</u>
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis, generalized.</u>
(e), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
<u>April 8, 1966</u>
<u>Through April 17, 1966</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
<u>19</u> | | 2Dd. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 8, 1966</u> , to <u>April 17, 1966</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>April 17, 1966</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Howard E. Hall</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>April 18, 1966</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Howard E. Hall, M.D.</u> | | | | 22d. ADDRESS
<u>Sykesville, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 23b. DATE THEREOF
<u>19 April 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Ft. Lincoln Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Prince George Co, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Warner E. Pumphrey, Inc.</u> | | | | ADDRESS
<u>8474 Georgia Avenue Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>APR 21 1966</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05135

CERTIFICATE OF DEATH

05134

| | | | | | | | | | |
|--|--|-------------------------------------|---|---|--|--|--------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | | c. LENGTH OF STAY IN IB
25 dys. | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | | | d. STREET ADDRESS
No fixed address | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First SHERMAN Middle HENRY Last PHEFFER | | | | 4. DATE OF DEATH
Month APRIL Day 16 Year 19 66 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7-5-11 | | 9. AGE (In years past birthday)
54 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unk. | | | | 14. MOTHER'S MAIDEN NAME
Anne Harris | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes (Unk.) | | | 16. SOCIAL SECURITY NO.
218-05-5888 | | 17. INFORMANT Address
Records, Springfield State Hospital | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral bronchopneumonia
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
491X | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-21-66 , 19____, to 4-16-66 , 19____, that (I) (we) last saw the deceased alive on 4-16-66 , 19____, and that death occurred at 9:15 AM , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<i>Octavio A. Ruiz</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
4-19-66 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Octavio A. Ruiz, M.D. | | | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | | | | | |
| 23a. BURIAL-CREMATION, REMEM. (Specify)
REMOVED | | 23b. DATE THEREOF
4-22-66 | | 23c. NAME OF CEMETERY OR CREMATORY
AMT. B.D. U. of Md. | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MD. | | | |
| 24. FUNERAL DIRECTOR
<i>Newell Funeral Home</i> | | | | ADDRESS
<i>Potomac 16-8 NW</i> | | 25a. REC'D BY REGISTRAR
APR 25 1966 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05130

05135

TESTIMONY OF DEATH

Carroll, Mary Ann, 35 yrs. 11 mos. 11 days

Carroll, Mary Ann, 35 yrs. 11 mos. 11 days

Carroll, Mary Ann, 35 yrs. 11 mos. 11 days

Carroll, Mary Ann, 35 yrs. 11 mos. 11 days

Carroll, Mary Ann, 35 yrs. 11 mos. 11 days

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Carroll, Mary Ann, 35 yrs. 11 mos. 11 days

Carroll, Mary Ann, 35 yrs. 11 mos. 11 days

APR 2 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|----------------------------------|---|--|--|--------------------------------|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville
c. LENGTH OF STAY IN 1b 9yr. 11mo. 4da.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 641 Silver Spring Ave.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print)
Herbert William Priestley | | | 4. DATE OF DEATH
Month 4 Day 25 Year 1966 | | | | | | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-8-85 | | 9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | | 10b. KIND OF BUSINESS OR INDUSTRY -- Building | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME William Priestley | | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Penophyl | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown | | | 16. SOCIAL SECURITY NO. 579-07-1409 | | 17. INFORMANT Hospital Records Address | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. CAUSE WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
4200 DUE TO Generalized arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome, associated with psychotic reaction | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH years
years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) -- | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. -- p.m. -- 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that the (this hospital) attended the deceased from 5-21 , 19 56 , to 4-25 , 19 66 , that he (we) last saw the deceased alive on 4-25 , 19 66 , and that death occurred at 5-49A , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Herbert H. Klaatuh M.D. | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 4-25-66 | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Dr H. F. KLAATUH | | | 22d. ADDRESS Springfield State Hospital | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4-28-66 | | 23c. NAME OF CEMETERY OR CREMATORY Glennwood Cemetery | | | 23d. LOCATION (City, town or county) (State) Washington, D.C. | | | | |
| 24. FUNERAL DIRECTOR Harry Haight Sykesville, Md. | | | ADDRESS | | 25a. REC'D BY REGISTRAR MAY 2 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05137

05136

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY Carroll
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Howard | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural--Sykesville | | c. LENGTH OF STAY IN lb
2mo. 7days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | e. STREET ADDRESS
Route #1 | |
| 3. NAME OF DECEASED (Type or print)
First Gladys Middle Ethel Last Ranlett | | 4. DATE OF DEATH
Month 4 Day 25 Year 19 66 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/15/90 |
| 9. AGE (In years last birthday) yrs.
75 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Waitress | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Washington D.C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Daniel Sullivan | | 14. MOTHER'S MAIDEN NAME
unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
578-09-1290 | |
| 17. INFORMANT
Springfield Hospital records-Sykesville | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Occlusion of left coronary artery due to
DUE TO
thrombosis
(c) | | INTERVAL BETWEEN ONSET AND DEATH
min. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction. | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/18/ 19 66 to 4/25/ 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/25/ 19 66 , and that death occurred at 12:35 p.m. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Edmee J. Reeves</i> | | 22b. DATE SIGNED
4/25/66 | |
| 22c. PHYSICIAN'S NAME (Type)
Edmee J. Reeves, M. D. | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/29/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia | |
| 24. FUNERAL DIRECTOR
The S. H. Hines Company - Washington, D.C. | | 25a. REC'D BY REGISTRAR
APR 28 1966 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0513

0513

DEPARTMENT OF HEALTH

Carroll

Maryland

Howard

Inter-Community

Enc. 1000

Inter-Community

Springfield State Hospital

Route 1

Blacks

Blacks

Blacks

Female

White

X

White

75

Washington D.C.

Washington D.C.

Partial admission

Unknown

no

75-0-1290 Springfield Hospital records - 1/1/64

only significant information

Continued at left coronary artery due to

thrombosis

Coronary artery syndrome associated with cerebral arteriosclerosis
with psychotic reaction.

X

4527

5187

55 a.m. 1/1/64

James J. Keever, M.D.

Springfield State Hospital
Springfield, Maryland

RECEIVED - MAY 19 1964
DEPARTMENT OF HEALTH
MAY 19 1964

CERTIFICATE OF DEATH

05138

05137

| | | | | | | | |
|---|---|---|---|--|--|---|------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Westminster Rural</u> | | c. LENGTH OF STAY IN 1B
<u>1 Month</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Westminster Rt. 3</u> | | d. STREET ADDRESS
<u>Snydersburg Road</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Cranberry Road Rt. #4</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Thomas</u> Middle <u>Dewey</u> Last <u>Rayner</u> | | | | 4. DATE OF DEATH
Month <u>April</u> Day <u>14</u> Year <u>1966</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Caucasian</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 1, 1898</u> | 9. AGE (in years last birthday)
<u>68</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Coal Miner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Coal Mines</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Frostburg, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Thomas D. Rayner</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Carr</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-235-3022</u> | | 17. INFORMANT
<u>Christina Leptic-</u> Address <u>R-1 Brodbeck's, Pa.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
<u>241X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asthma + emphysema</u>
DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>30 min</u>
<u>5-10 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/19</u> , 19 <u>65</u> , to <u>4/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/14</u> , 19 <u>66</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above. | | | | | | | 22b. DATE SIGNED |
| 22a. SIGNATURE
<u>Donald A. Knight, MD</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22d. ADDRESS
<u>Greenmount, Md</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Donald A. Knight, MD.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>4/18/66</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Evergreen Memorial Gardens</u> | 23d. LOCATION (City, town or county) (State)
<u>Finksburg Maryland</u> | | | | |
| 24. FUNERAL DIRECTOR
<u>John E. Galt</u> | | ADDRESS
<u>Hampstead, Md. 21074</u> | | 25a. REC'D BY REGISTRAR
<u>APR 18 1966</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10107

10107

10107

APR 18 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

Reg. Dist. No. 05138

05139

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Westminster</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Westminster</u> 06-1 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS
<u>6 Wimert Avenue</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>George</u> Middle <u>Emerson</u> Last <u>Rue</u> | | 4. DATE OF DEATH
Month <u>April</u> Day <u>5</u> Year <u>1966</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 23, 1903</u> |
| 9. AGE (In years last birthday)
<u>63</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Machinery Operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Road building</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Cambridge, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Tilden W. Rue</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Etta Wroten</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>218-09-0521</u> | |
| INFORMANT
<u>Mrs. Marion Rue, Taneytown, Maryland</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchectasis</u>
526X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic emphysema</u>
DUE TO (c) <u>Chronic Malnutrition</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4/5</u> , 19 <u>66</u> , to <u>4/5, 1966</u> , that I last saw the deceased alive on <u>Never</u> , 19 <u> </u> , and that death occurred at <u>7 45 AM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>150 W. Main St</u> DATE SIGNED <u>4-5-66</u> | | | |
| ACTUAL SIGNATURE <u>William R O'Rourke</u> M.D. | | PHYSICIAN'S NAME (Type) <u>William R O'Rourke</u> <u>Westminster, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Apr. 7, 1966</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Grace Reformed Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Taneytown, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John H. Skiles</u> | | 24a. REG'D BY REGISTRAR
<u>APR 7 1966</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

1915

CERTIFICATE OF DEATH

1915

1. Name of deceased: William R. Brown

2. Sex: Male

3. Age: 45

4. Date of death: Jan 15 1915

5. Place of death: Home

6. Cause of death: Heart disease

7. Signature of physician: Wm. R. Brown

8. Signature of registrar: Wm. R. Brown

9. Signature of informant: Wm. R. Brown

10. Date of registration: Jan 15 1915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 05140 | | | | | | | | | | |
| 05139 | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Westminster
c. LENGTH OF STAY IN 1b
6 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
67 W. Green Street | | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Westminster
d. STREET ADDRESS
67 W. Green Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
RALPH WHITELEY SCOTT | | | | | 4. DATE OF DEATH
Month
April
Day
15
Year
1966 | | | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
April 21, 1892 | | 9. AGE (In years last birthday)
73 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
structural designer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Wilmington, Del. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
George Whiteley Scott | | | | | 14. MOTHER'S MAIDEN NAME
Byella ? | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
-- | | 16. SOCIAL SECURITY NO.
152-07-1065 | | 15. INFORMANT
Mrs. Gladys M. Wimert | | | Address
67 W. Green St. Westminster, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
1621
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,
(b) Bronchial Carcinoma
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Arteriosclerotic Cardio-vascular disease | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1/66
to 4/14/66 | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
while <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/7/63 , 19 63 , to 4/1 , 19 66 , that (I) (we) last saw the deceased alive on 4/1 19 66 , and that death occurred at 6:55 AM, from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
William R O'Rourke | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
WILLIAM R O'Rourke | | | | | 22d. ADDRESS
W. Main St. Westminster Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE THEREOF
4/17/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Westminster Cemetery | | 23d. LOCATION (City, town or county) (State)
Westminster, Maryland | | | | |
| 24. FUNERAL DIRECTOR
J. E. Myers, Jr. Westminster, Md. | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
APR 19 1966 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|---|---|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 05141 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN 1b
12yrs.2mos.26dys
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
804 Wellington Ave.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
ODEN | | | First
ODEN | | Middle
SHERIDAN | | Last
SHIPLEY | | 4. DATE OF DEATH
Month
APRIL
Day
4
Year
19 66 | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
3-11-13 | | 9. AGE (In years last birthday)
53 yrs. | | IF UNDER 1 YEAR
Months
30
Days
4 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic at Beth. Steel Co. | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Thomas L. Shipley | | | | | 14. MOTHER'S MAIDEN NAME
Fannie Shoemaker | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | 16. SOCIAL SECURITY NO.
214-14-9331 | | 17. INFORMANT
Records, Springfield State Hospital
Address | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral bronchopneumonia
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Possible infected emboli from right ventricle
DUE TO
(c) wall
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
CBS assoc. with convulsive disorder, without qualifying phrase | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Days

Days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Carrollton, Md. | | (County)
Carrollton, Md. | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1-8-54 , 19 54 , to 4-4-66 , 19 66 , that (I) (we) last saw the deceased alive on 4-4-66 , 19 66 , and that death occurred at 7:05 AM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Frances Reid Nabors | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
4/4/66 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Frances Reid Nabors, M. D. | | | | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
4/7/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Church of God Ce., | | 23d. LOCATION (City, town or county)
Carrollton, Md. | | | | |
| 24. FUNERAL DIRECTOR
Robert C. Altenburg - 6009 Harford Rd.
Funeral Home, Inc. | | | | | ADDRESS
6009 Harford Rd. | | 25a. REC'D BY REGISTRAR
APR 11 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

CERTIFICATE OF DEATH

05142

05141

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY CARROLL
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER
c. LENGTH OF STAY IN 1b 9 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 37 E. GEORGE ST. | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER
d. STREET ADDRESS 37 E. GEORGE ST. a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last HOWARD IRVING SIES | | | | 4. DATE OF DEATH Month Day Year APRIL 19 1966 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MAY 17 1898 yrs. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN | | 10b. KIND OF BUSINESS OR INDUSTRY BUILDING | | 11. BIRTHPLACE (County & State, or foreign country) CARROLL MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HOWARD PETER SIES | | | | 14. MOTHER'S MAIDEN NAME LAURA KATE BURGOON | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 216-10-0331 | | 17. INFORMANT MRS. MARY P. SIES Address WESTMINSTER, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF LUNG (b) 163X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 2 YEARS INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from APRIL 19 1966 to APRIL 19 1966 that (I) (we) last saw the deceased alive on APRIL 19 1966 and that death occurred at 4:30 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Daniel I. Welliver M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 4-19-66 | |
| 22c. PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER | | | | 22d. ADDRESS 19 RIDGE ROAD WESTMINSTER, MD. | | | |
| 23a. BURIAL REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 4/21/66 | | 23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH CEMETERY | | 23d. LOCATION (City, town or county) (State) WESTMINSTER, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE James G. Saffell Jr. | | | | 25a. REC'D BY REGISTRAR APR 20 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15141

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CAROLINA OF LUNG 2 YEAR
 WESTMINSTER, MD
 MRS. MARY P. SIEZ
 HOWARD PETER SIEZ LAURA KATE BURGESS
 ELECTRICIAN BUILDING CARROLL MARYLAND U.S.A.
 MAY 17 1898
 MALE WHITE
 HOWARD IRVING SIEZ - APRIL 19 1898
 31 E. LEWIS ST. 31 E. CLARK ST.
 WESTMINSTER 2 YEARS WESTMINSTER
 CARROLL

DANIEL J. WELLIVER
 RIDGE ROAD
 WESTMINSTER, MD
 APRIL 19 1898
 APRIL 19 1898
 DANIEL J. WELLIVER
 RIDGE ROAD
 WESTMINSTER, MD
 APRIL 19 1898

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05143

05142

| | | | | | | | |
|--|--|--|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>
c. LENGTH OF STAY IN <u>2 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Long View Nursing Home Inc</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>
d. STREET ADDRESS <u>Brodbeck Road</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>John</u> <u>Meldon</u> <u>Simmons</u> | | 4. DATE OF DEATH
Month <u>April</u> Day <u>25</u> Year <u>1966</u> | | 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Maryland</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | 13. FATHER'S NAME <u>John Simmons</u> | | 14. MOTHER'S MAIDEN NAME <u>Alice Spencer</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. <u>219-36-1014</u> | | 17. INFORMANT <u>Mrs John Simmons</u> Address <u>Hampstead, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u>
177X DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 yrs</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | 21. I certify that (I) (this hospital) attended the deceased from <u>March 1963</u> to <u>April 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>4-25-1966</u> , and that death occurred at <u>4:35</u> A.M. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>M.C. Porterfield</u> | | 22b. DATE SIGNED
<u>4-26-66</u> | | 22c. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u> | | | |
| 22d. ADDRESS
<u>Hampstead, Md.</u> | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>April 28, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead Cemetery</u> | | | |
| 23d. LOCATION (City, town or county) <u>Hampstead</u> (State) <u>Md.</u> | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton-Eline Funeral Home</u> ADDRESS <u>Hampstead Md.</u> | | | | | |
| 25a. REC'D BY REGISTRAR <u>MAY 2 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|---|---|--|---|--|--|
| 05144 | | | | | 05143 | | | | | | | | | |
| 1. PLACE OF DEATH
a. CDUNTY
Carroll | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | | | | b. COUNTY
Baltimore City | | | | | | | | | |
| c. LENGTH OF STAY IN 1b
10 mos. 16 dys. | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | | d. STREET ADDRESS
8601 Gray Fox Rd.
Elkridge, Prince Georges Avenue | | | | | | | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) | | | First
ISADORE | | | Middle
(NMN) | | | Last
SINSKEY | | | | | |
| 5. SEX
Male | | | 6. COLOR OR RACE
White | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH
2-15-1890 | | | | | |
| 9. AGE (In years last birthday)
76 yrs. | | | 10. DATE OF DEATH
APRIL 6 1966 | | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland, Baltimore | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
Albert Sinskey | | | | | 14. MOTHER'S MAIDEN NAME
Sarah (last name unk.) | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | | | 16. SOCIAL SECURITY NO.
217-01-5099 A | | | | | 17. INFORMANT
Records, Springfield State Hospital | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
446 X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis
DUE TO (c) Generalized arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
CBS assoc. with senile brain disease, with psychotic reaction | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Months
Years
Years | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 5-20-65, 19 to 4-6-66, 19, that (I) (we) last saw the deceased alive on 4-6-66, 19, and that death occurred at 11:00 PM, from the causes and on the date stated above. | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 22a. SIGNATURE
Frances Reid Nabors | | | | | | | | | | 22b. DATE SIGNED
4-6-66 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Frances Reid Nabors, M. D. | | | | | | | | | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
April 8, 1966 | | | 23c. NAME OF CEMETERY OR CREMATORY
Hebrew Friendship | | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Sol Levinson & Bros. Inc. 6010 Reisterstown Rd. | | | | | | | | | | 25a. REC'D BY REGISTRAR
APR 12 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05144

| | | | | | | |
|--|----------------------------------|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
CARROLL
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
SYKESVILLE
c. LENGTH OF STAY IN 1b
2 YRS - 10 MOS - 11 DYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SPRINGFIELD STATE HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
BALTIMORE CITY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
BALTIMORE
d. STREET ADDRESS
906 W. 31ST STREET
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First
Goldie
Middle
NMN
Last
SMITH | | 4. DATE OF DEATH
Month
APRIL
Day
17
Year
19 66 | | | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED
<input type="checkbox"/> NEVER MARRIED
<input checked="" type="checkbox"/> WIDDED
<input type="checkbox"/> DIVORCED | 8. DATE OF BIRTH
9-6-1892 | 9. AGE (In years last birthday)
73 yrs. | IF UNDER 1 YEAR
Months
7
Days
3 | IF UNDER 24 HRS.
Hours
15
Min.
00 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
WILLIAM F. MCKEE | | | 14. MOTHER'S MAIDEN NAME
AMELIA | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
214-24-9039 | | 17. INFORMANT
RECORDS, SPRINGFIELD STATE HOSPITAL
Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4221
DUE TO
(b) Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes Mellitus - CHRONIC BRAIN SYNDROME WITH CEREBRAL ARTERIOSCLEROSIS WITH PSYCHOTIC REACTION. | | | | | INTERVAL BETWEEN ONSET AND DEATH
years
years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 6-8-63 , 19__, to 4-17-66 , 19__, that (I) (we) last saw the deceased alive on 4-17-66 , 19__, and that death occurred at 3:45 PM , from the causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE
Octavio A. Ruiz | | M.D. ATTENDING PHYS.
<input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
4-17-66 | | |
| 22c. PHYSICIAN'S NAME (Type)
Octavio A. Ruiz | | 22d. ADDRESS
SPRINGFIELD STATE HOSPITAL
SYKESVILLE, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
4/20/66 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKWOOD | | 23d. LOCATION (City, town or county) (State)
BALTO. MD. |
| 24. FUNERAL DIRECTOR
Carl E. Chomicki | | ADDRESS
3617 Chestnut Ave | | 25a. REC'D BY REGISTRAR
APR 20 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

05143

05143

UNITED STATES OF AMERICA

DATE NO.

THREE MONTHS

OFFICE

BRANCH

APR 11 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|-----------------------------------|---|--|---|------------------------------------|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 05146 | | | | | 05145 | | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | | |
| a. COUNTY
Carroll | | | | | a. STATE
Maryland | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | | | | b. COUNTY
Carroll | | | | | | |
| c. LENGTH OF STAY IN 1b
2yr. 6mos. 23dys. | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Woodbine | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | | d. STREET ADDRESS
06-1 | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | 4. DATE OF DEATH | | | | | | |
| First Middle Last
JOHN JACOB SNYDER | | | | | Month Day Year
April 20 19 66 | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> | | 8. DATE OF BIRTH
4-12-74 | | 9. AGE (In years last birthday) 92 yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | |
| 13. FATHER'S NAME
Levy S. Snyder | | | | | 14. MOTHER'S MAIDEN NAME
Mary Jane Kesselring | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | | 16. SOCIAL SECURITY NO. 214-16-0951-A | | | | | | |
| | | | | | 17. INFORMANT Address
Records, Springfield State Hospital | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular Disease
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Years | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 9-27-63 , 19 to 4-20-66 , 19, that (I) (we) last saw the deceased alive on 4-20-66 , 19, and that death occurred at 3:30 p.m. M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Octavio A. Ruiz | | | | | 22b. DATE SIGNED
4-20-66 | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Octavio A. Ruiz, M.D. | | | | | 22d. ADDRESS
Springfield State Hospital, Sykesville, Maryland 21784 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
4/23/66 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Marys Cemetery | | 23d. LOCATION (City, town or county) (State)
Silver Run, Md. | | | | |
| 24. FUNERAL DIRECTOR
J. E. Myers, Jr., Westminster, Md. | | | | | 25a. REC'D BY REGISTRAR
APR 22 1966 | | | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|-------------------------------|--|----------------------------------|--|---|--|--|--|--|---|--|
| 05147 | | | | | 05146 | | | | | | |
| Item 8 Film G272 4/15/66 mh | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Carmel</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md.</u>
c. LENGTH OF STAY IN 1b <u>2 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home 128 N. Main</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u>
b. COUNTY <u>Balto.</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Old Hayford Rd. Balto Co. Md 03-1</u>
d. STREET ADDRESS <u>Sonn Lane (no number)</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED
(Type or print) | | First <u>John</u> Middle <u>—</u> Last <u>Sonn</u> | | 4. DATE OF DEATH | | Month <u>4</u> Day <u>7</u> Year <u>1966</u> | | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-9-1890</u> | 9. AGE (In years last birthday) <u>75</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Balto Co Parkville Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | | | |
| 13. FATHER'S NAME <u>Henry Sonn</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Henrietta Hayes</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>217-46-2111</u> | | 17. INFORMANT <u>Cinn Davis (daughter)</u> | | Address <u>Rt 41 Box 2629 Manchester, Md</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
<u>332x</u> DUE TO (b) <u>Arterio-Sclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
<u>unknown</u> | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-6</u> , 19 <u>66</u> , to <u>4-7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-6</u> , 19 <u>66</u> , and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>M.C. Porterfield</u> | | | | 22b. DATE SIGNED <u>4-8-66</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u> | | | | 22d. ADDRESS <u>Hampstead, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>4-11-1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Co. Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7701 Belair Road</u> | | | | 25a. REC'D BY REGISTRAR <u>APR 12 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|--|--|--|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 05148 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Carroll</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Keymar Rural 106-1</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll County General</u> | | | | | | d. STREET ADDRESS _____ | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>BABY</u> First <u>BOY</u> Middle <u>STAMBAUGH</u> Last <u>STAMBAUGH</u> | | | | | | 4. DATE OF DEATH <u>4</u> <u>12</u> <u>1966</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4/12/66</u> | | 9. AGE (In years last birthday) <u>2</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Carroll</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Larry STAMBAUGH</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary F. BLACK</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Y</u> | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INEDMANT <u>Mary Stambaugh</u> Address <u>Keymar MD</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Immaturity (Birth wgt 11'8")</u>
7615 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ABRUPTIO PLACENTA</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-12</u> , 19 <u>66</u> , to <u>4-12</u> , 19 <u>66</u> , that <u>MY</u> (we) last saw the deceased alive on <u>4-12</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Karl W Green</u> M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>4/12/66</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>KARL W GREEN</u> | | | | | | 22d. ADDRESS <u>WESTMINSTER MD</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>4/13/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>UNION</u> | | 23d. LOCATION (City, town or county) (State) <u>KEYSVILLE MD</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>DD Hartzler & Sons Union Bridge Md</u> ADDRESS _____ | | | | | | 25a. REC'D BY REGISTRAR <u>APR 15 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u> | | | |

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(3)

APR 1 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 05149 | | Item 9 Form 5/2/66 | | 5/2/66 | | 05148 | | | |
| 1. PLACE OF DEATH
a. COUNTY <i>Carroll</i> | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Liberty</i> | | c. LENGTH OF STAY IN 1b <i>4/25/66</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Md</i> | | b. COUNTY <i>Balto</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Golden Gate Home</i> | | e. STREET ADDRESS <i>8406 Allenwood Rd</i> | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i> | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>Nancy</i> Middle <i>Stansbury</i> Last <i>Stansbury</i> | | 4. DATE OF DEATH
Month <i>April</i> Day <i>25</i> Year <i>1966</i> | | 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
Month <i>May</i> Day <i>7</i> Year <i>1886</i> | | 9. AGE (In years last birthday) <i>80</i> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <i>North Carolina</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Richard Baker</i> | | 14. MOTHER'S MAIDEN NAME <i>Nancy Price</i> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | |
| 16. SOCIAL SECURITY NO. <i>none</i> | | 17. INFORMANT <i>Mr Randolph Stansbury</i> | | Address <i>8406 Allenwood Rd Randallstown</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Vascular</i>
DUE TO <i>Myocarditis</i>
DUE TO <i>Heart Arteriosclerosis</i>
(c) <i>Chronic</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <i>19</i> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from <i>Apr 21</i> , 19 <i>66</i> to <i>Apr 25</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Apr 24</i> , 19 <i>66</i> , and that death occurred at <i>11:30</i> M., from the causes and on the date stated above. | |
| 22a. SIGNATURE <i>M V Mastin</i> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <i>4/25/66</i> | | 22c. PHYSICIAN'S NAME (Type) <i>M V MASTIN</i> | | | |
| 22d. ADDRESS <i>Baltimore Md.</i> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>4/28/66</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Freedom Park</i> | | 23d. LOCATION (City, town or county) (State) <i>Balto Md</i> | |
| 24. FUNERAL DIRECTOR <i>Frank Byers</i> | | ADDRESS <i>8728 Liberty Rd Randallstown</i> | | 25a. REC'D BY REGISTRAR <i>Charles Judge</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |
| DATE <i>APR 28 1966</i> | | | | | | | | | |

1914

W. H. ...

May 11th 1914

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst.

in relation to the ...

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,

W. H. ...

Special Agent in Charge

...

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CERTIFICATE OF DEATH

05150

05149

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN lb
23yrs.2mos.6dys.
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | d. STREET ADDRESS
Exact address unknown | |
| 3. NAME OF DECEASED (Type or print)
First
ETHEL
Middle
SIMES
Last
STEINER | | 4. DATE OF DEATH
Month
APRIL
Day
25
Year
19 66 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
4-24-1883 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Librarian | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years
1st birthday)
83
yrs. |
| 11. BIRTHPLACE (County & State, or foreign country)
New York | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Mulligan | | 14. MOTHER'S MAIDEN NAME
Isabel Simes | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-46-3747 | |
| 17. INFORMANT
Records, Springfield State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Severe bronchopneumonia
4200 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease
DUE TO
(c) Generalized arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH
Days
Years
Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Schizophrenic reaction, paranoid type | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 2-19-43 , 19__ to 4-25-66 , 19__, that (I) (we) last saw the deceased alive on 4-25-66 , 19__, and that death occurred at 10:05 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Agustin del Campo</i> | | 22b. DATE SIGNED
4-25-66 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
4/27/1966 | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | 25a. REC'D BY REGISTRAR
DATE | |
| ADDRESS
4905 York Road
Balto. 12, Md. | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

APR 26 1966

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11. *Staphylococcus aureus*

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Abstract

[illegible]

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agencia del campo

CERTIFICATE OF DEATH

05151

05150

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN lb
10 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | e. STREET ADDRESS
3405 Duvall Avenue | |
| 3. NAME OF DECEASED (Type or print)
First Katharine Middle Mary Last STEPHENS | | 4. DATE OF DEATH
Month April Day 24 Year 1966 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-28-1878 |
| 9. AGE (In years last birthday)
87 yrs. | | 10. IF UNDER 1 Year
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none - AT Home | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John T. McMahon - dec. | | 14. MOTHER'S MAIDEN NAME
Katherine Wallace - dec. Jacksonville, Florida | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
none | | 16. SOCIAL SECURITY NO.
213-54-1807 | |
| 17. INFORMANT
Joseph L Stephens - 1315 Talbot Ave - Springfield State Hospital Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) heart failure.
4200 DUE TO
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease with congestive
DUE TO (c) Generalized arteriosclerosis. | | | INTERVAL BETWEEN ONSET AND DEATH
years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 4-14-66 , 19__, to 4-24-66 , 19__, that (I) (we) lost saw the deceased alive on 4-24-66 , 19__, and that death occurred at 3 p.m. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. Antonius Glahn, M.D. | | 22b. DATE SIGNED
4-24-66 | |
| 22c. PHYSICIAN'S NAME (Type)
Antonius Glahn, M.D. | | 22d. ADDRESS
Springfield State Hospital Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
4-27-66 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery - Baltimore, Md | 23d. LOCATION (City or Town) (County) (State) |
| 24. FUNERAL DIRECTOR
Ellsworth Armacost - 4600 Robert, Heights Ave | | 25a. REC'D BY REGISTRAR
APR 26 1966 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | |
|---|--|----------------------------------|--|--|--|--|--|---|--|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 05152 | | | | | | | | | | | | | | | |
| 05151 | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. CDUNITY Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural, Westminster
c. LENGTH OF STAY IN MD
6 Years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Westminster, Md. R. D. 4 | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. CDUNITY Carroll
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural, Westminster
d. STREET ADDRESS
Westminster, Md. R. D. 4
e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
GERTIE A. STONESIFER | | | | | 4. DATE OF DEATH
Month April Day 12 Year 1966 | | | | | | | | | | |
| 5. SEX
F | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/7/1896 | | 9. AGE (In years last birthday)
69 yrs. | | IF UNDER 1 YEAR
Months 06 Days 1 | | IF UNDER 24 HRS.
Hours 1 Min. 5 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife-Housework | | | | 10b. KIND OF BUSINESS OR INDUSTRY
The Family Home | | | | 11. BIRTHPLACE (County & State, or foreign country)
Carroll County, Md. | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
John Stonesifer | | | | | | 14. MOTHER'S MAIDEN NAME
Ellen Stonesifer | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
218-52-3477 | | 17. INFORMANT
Mrs. Mazie Zepp Westminster, Md. R.D.1 | | | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive cardiovascular disease
(c) Stroke
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Viral pneumonia | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
about 1 hrs 5 yrs | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19 p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 1, 1964 to Apr 12, 1966 that (I) (we) last saw the deceased alive on Apr 1, 1966 , and that death occurred at 4:00 AM , from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
E. Reese Wilkens | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4-12-66 | | | |
| 22c. PHYSICIAN'S NAME (Type)
E. Reese Wilkens | | | | | | | | | | 22d. ADDRESS
15 Kemper Westminister Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
4/14/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Bachmans Valley Cemetery | | | | 23d. LOCATION (City, town or county) (State)
Bachmans Valley, Carroll Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR
Richard A. Little, Littlestown PA | | | | | | | | | | 25a. REC'D BY REGISTRAR
APR 14 1966 | | 25b. REGISTRAR'S SIGNATURE
J Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|---|--|---------------------------------------|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 05153 CERTIFICATE OF DEATH 05152 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN 1b
7 mos. 2 dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown
d. STREET ADDRESS
33 West Wilson Boulevard
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
SUSAN TICE STOUFFER | | | | | 4. DATE OF DEATH
Month Day Year
April 5 19 66 | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10-23-1886 | | 9. AGE (In years last birthday)
79 yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Seamstress | | 10b. KIND OF BUSINESS OR INDUSTRY
-- | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | |
| 13. FATHER'S NAME
George Sterling | | | | | 14. MOTHER'S MAIDEN NAME
Anna Newcomer | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
220-05-6176A | | 17. INFORMANT
Address
Records, Springfield State Hospital | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE AND CEREBRAL ARTERIOSCLEROSIS
4200 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic brain syndrome associated with senile brain disease, with psychotic reaction. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
YEARS
YEARS | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 9-3-65 , 19__ to 4-5-66 , 19__, that (I) (we) last saw the deceased alive on 4-5-66 , 19__, and that death occurred at 3:15 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Agustin del Campo M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | | | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland 21784 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
4/8/66 | | 23c. NAME OF CEMETERY OR CREMATORY
ROSE HILL | | | 23d. LOCATION (City, town or county) (State)
HAGERSTOWN, MD | | | | |
| 24. FUNERAL DIRECTOR
W. T. Norment | | | | | ADDRESS
Hagerstown | | 25a. REC'D BY REGISTRAR
APR 12 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 05154 | | | | | 05153 | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN 1b
37yrs.6mos.26dys.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Springfield State Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
(unknown)
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First
JOHN
Middle
D.
Last
STREAKER | | | 4. DATE OF DEATH
Month
APRIL
Day
22
Year
19 66 | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7-1-09 | | 9. AGE (In years last birthday)
56 yrs.
IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/>
IF UNDER 24 HRS: Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John W. Streaker | | | | | 14. MOTHER'S MAIDEN NAME
Mary E. Donaldson | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Records, Springfield State Hospital
Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia in status epilepticus
3532
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pulmonary edema
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic brain syndrome associated with convulsive disorder, without qualifying phrase.
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| MEDICAL CERTIFICATION
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
19
20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 9-26 , 19 68 , to 4-22 , 19 66 , that (1)-(we) last saw the deceased alive on 4-22 19 66 , and that death occurred at A M, from the causes and on the date stated above.
22a. SIGNATURE
Ilse Kamm
22b. DATE SIGNED
4-22-66
22c. PHYSICIAN'S NAME (Type)
Ilse Kamm, M.D.
22d. ADDRESS
Sykesville, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
April 25, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn | | 23d. LOCATION (City, town or county) (State)
Baltimore Co., Maryland | | | |
| 24. FUNERAL DIRECTOR
Burgess Funeral Home
ADDRESS
3631 Falls Road
Norace F. Burgess | | | | | 25a. RECEIVED BY REGISTRAR
APR 25 1966
DATE | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 05155 | | | | | 05154 | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN ID
6 yrs. 4 mos. 5 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Springfield State Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
1733 Terrell Place
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
WILLIAM (NMN) SYKES | | | 4. DATE OF DEATH
Month Day Year
April 6 19 66 | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8-21-02 | | 9. AGE (In years last birthday)
63 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Transportation | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland Baltimore | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
John Schellenberger | | | | | 14. MOTHER'S MAIDEN NAME
Mary E. Robinson | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
217-03-9229 | | 17. INFORMANT
Mrs Anna M. Hellman Address 3006 Weaver Ave
Records, Springfield State Hospital | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary artery thrombosis
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c) Far advanced pulmonary tuberculosis, active
years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic brain syndrome associated with brain trauma, gross force, with psychotic reaction. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
minutes | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-1-59 , to 4-6-66 , 19 66 , that (I) (we) last saw the deceased alive on 4-6-66 , 19 66 , and that death occurred at 10:15 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Julian Radzykewycz M.D. | | | | 22b. DATE SIGNED
4-6-66 | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Julian Radzykewycz, M.D. | | | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland 21784 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/9/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
HENRY SANDER & SONS INC BALTIMORE MD. | | | | 25a. REC'D BY REGISTRAR
APR 12 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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CERTIFICATE OF DEATH

05155

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| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u>
c. LENGTH OF STAY IN b. <u>1</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home 128 N Main St</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md</u>
b. COUNTY <u>Carroll</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>
d. STREET ADDRESS <u>1195 Main St</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Gabriel Virginia Thieret</u>
First Middle Last
4. DATE OF DEATH <u>April 24 1966</u>
Month Day Year | | 5. SEX <u>Female</u>
6. COLOR OR RACE <u>White</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>March 23, 1876</u>
9. AGE (in years last birthday) <u>90</u> yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Manchester, Md. (Carroll)</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | | 13. FATHER'S NAME <u>Valentine D. Manthey</u>
14. MOTHER'S MAIDEN NAME <u>Hennietta Cressine</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)
16. SOCIAL SECURITY NO. <u>219-036258</u>
17. INFORMANT <u>George Thieret (husband)</u> Address <u>1195 Main St Manchester Md.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
332X DUE TO (b) <u>Cerebral Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u>
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1950</u> to <u>April 24, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 23, 1966</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>W. H. Foward</u> M.D.
22c. PHYSICIAN'S NAME (Type) <u>W. H. Foward MD</u> | | 22b. DATE SIGNED <u>4/24/66</u>
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <u>Manchester, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>
23b. DATE THEREOF <u>April 27, 1966</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Manchester Cemetery</u>
23d. LOCATION (City, town or county) (State) <u>Manchester Md.</u> | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton- Eline Funeral Home Hampstead, Md.</u> ADDRESS <u>—</u>
25a. REC'D BY REGISTRAR <u>MAY 2 1966</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05155

STATE OF NEW YORK

05155

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "received" and "paid" are faintly visible.]

MAY 2 1966

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|--|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>CARROLL</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u>
c. LENGTH OF STAY IN 1b <u>LIFE</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12 GILL AVE</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD Maryland</u>
d. STREET ADDRESS <u>12 GILL AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>METTIE BELLE TIPTON</u> | | | 4. DATE OF DEATH
Month <u>April</u> Day <u>25</u> Year <u>1965</u> | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 4, 1881</u> | | 9. AGE (in years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | |
| 13. FATHER'S NAME <u>G. Phillip Fuhrman</u> | | | 14. MOTHER'S MAIDEN NAME <u>EMMA HOUCK</u> | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | 16. SOCIAL SECURITY NO. <u>220-34-5754</u> | | 17. INFORMANT <u>Edward C Tipton</u> Address <u>HAMPSTEAD, MD</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
443X DUE TO <u>Arteriosclerotic Cerebrovascular disease</u>
(b) DUE TO <u>Hypertension</u>
(c) <u>Hypertension</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1959</u> , to <u>April 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 24, 1966</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Joseph E. Bush MD</u> | | | | 22b. DATE SIGNED <u>April 25, 1966</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u> | | 22d. ADDRESS <u>HAMPSTEAD Maryland</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>April 28, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Hampstead, Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home</u> | | | | ADDRESS <u>Hampstead, Md.</u> | | 25a. REC'D BY REGISTRAR <u>MAY 2 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

1858

Received of the
Honorable John
C. Calhoun
the sum of
Five Dollars
for the
purchase of
a copy of
the
Report of the
Committee on
the
State of
the
Union
for the
Year
1857

Witness my hand
this 1st day of
May 1858

John C. Calhoun
Secretary of the
Senate

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05158

05157

| | | | |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>CARROLL</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>
c. LENGTH OF STAY IN 1b <u>3 yrs. 7m. 22 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>FREDERICK</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Braunswick</u>
d. STREET ADDRESS <u>302-9th Ave.</u>
e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Ethel</u> Middle <u>Mary</u> Last <u>Utterback</u> | | 4. DATE OF DEATH
Month <u>April</u> Day <u>16</u> Year <u>1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-18-87</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>2</u> Min. <u>10-2</u> | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 11b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 12. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | 13. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 14. FATHER'S NAME <u>Samuel G. Hurst</u> | | 15. MOTHER'S MAIDEN NAME <u>Tacy Lanham</u> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> | | 17. SOCIAL SECURITY NO. <u>None</u> | |
| 18. INFIRMARY <u>Hospital records.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) <u>Arterio sclerotic cardio vascular disease</u>
DUE TO (c) <u>Generalized arterio sclerosis.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. associated with cerebral arteriosclerosis.</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (H) (this hospital) attended the deceased from <u>8-24</u> , 19 <u>62</u> , to <u>4-16</u> , 19 <u>66</u> , that (H) (we) last saw the deceased alive on <u>4-16</u> , 19 <u>66</u> , and that death occurred at <u>12:50</u> P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Suha Ozgun.</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>SUHA OZGUN</u> | | 22d. ADDRESS <u>Springfield State Hosp. Sykesville Maryland.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>4-19-66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Hillsboro Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Purcellville Va.</u> | |
| 24. FUNERAL DIRECTOR <u>Harry W. Haight</u> | | 25a. REC'D BY REGISTRAR <u>APR 19 1966</u> | |
| ADDRESS <u>Sykesville, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | |

05153

051

STATE OF TEXAS

County of _____

State of Texas

County of _____

State of Texas

County of _____

State of Texas

County of _____

State of Texas

County of _____

State of Texas

County of _____

State of Texas

County of _____

State of Texas

County of _____

State of Texas

County of _____

State of Texas

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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05158

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05158

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural, Westminster | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural, Westminster | | | |
| c. LENGTH OF STAY IN 1b
3 years | | | | d. STREET ADDRESS
82 E. Baltimore Road | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
82 E. Baltimore Road | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First PAUL Middle VARNELL Last VARNELL | | | | 4. DATE OF DEATH
Month April Day 11 Year 1966 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 21, 1925 | 9. AGE (In years last birthday)
40 yrs. | IF UNDER 1 YEAR
Months 06 Days 1 | IF UNDER 24 HRS.
Hours 1 Min. 00 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Merchant Seaman | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Kansas City, Missouri | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Harvey Varnell | | | | 14. MOTHER'S MAIDEN NAME
Bess Carroll | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
--- | | 16. SOCIAL SECURITY NO.
? | | 17. INFORMANT
Helen Maveric Varnell | | Address
same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound skull rt side
976x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Self Inflicted
DUE TO (c) Self Inflicted | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY. Month, Day, Year
1:30 a.m. 4-8-66 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
His Home | | 20f. (City or town) (County) (State)
Westminster Carroll Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
W. Glenn Speicher | | | | 22. DATE SIGNED
4-11-66 | | | |
| EXAMINER'S NAME (Type)
W. Glenn Speicher M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, City, County, State)
135 E. Main St. Westminster, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
removal | | 23b. DATE THEREOF
April 11, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Lafayette Cemetery | | 23d. LOCATION (City, town or county) (State)
Brier Hill, Penna. | |
| 24. FUNERAL DIRECTOR
L. E. Myers, Jr. Westminster, Md. | | | | 25a. REC'D BY REGISTRAR
APR 13 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

ADDITIONAL INFORMATION TO DEATH

General Information

25th Anniversary

General

Nov. 25, 1955

General Information

General

General Information

General Information

General Information

General Information

General Information

General Information

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General Information

General Information

General Information

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|-------------------------------------|---|---|--|--|--|---|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 05160 | | | | | 05159 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
CARROLL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAMPSTEAD
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAMPSTEAD
d. STREET ADDRESS
06-1
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
GEORGE | | | First
Z. | | Middle
WHEAT | | Last
WHEAT | | 4. DATE OF DEATH
Month
4
Day
11
Year
1966 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
October 12, 1900 | | 9. AGE (In years last birthday)
65 yrs. | | 10. IF UNDER 1 YEAR
Months
6
Days
11
Hours
11
Min.
1966 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 13. FATHER'S NAME
John Wheat | | | | | 14. MOTHER'S MAIDEN NAME
Susan Baker | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | | 16. SOCIAL SECURITY NO.
214-03-7099 | | 17. INFORMANT
Mrs. Robert Utz, Hampstead, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Septic relaps, embolus
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/4 , 19 64 , to 12/11 , 19 65 , that (I) (we) last saw the deceased alive on 12/11 , 19 65 , and that death occurred at 12/11 M, from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
D. H. Wright | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
M.D. 22d. ADDRESS | | | 22b. DATE SIGNED
APR 18 1966 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/14/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Mem. Gardens | | | 23d. LOCATION (City, town or county) (State)
Finksburg Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
Tipton-Eline | | | | | 25a. REC'D BY REGISTRAR
Hampstead, Md. | | | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | |

1515

OFFICE OF THE ATTORNEY GENERAL

1961

STATE OF NEW YORK

IN SENATE

January 12, 1961

REPORT

OF THE

COMMISSIONER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|----------------------------------|---|---|---|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 05161 | | | | | 05161 | | | | |
| 1. PLACE OF DEATH
a. COUNTY Carroll
b. CITY OR TDWN (if outside corporate limits, write RURAL and give nearest town) Sykesville RD#4
c. LENGTH OF STAY IN 1b 8 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Near Sykesville | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville RD#4
d. STREET ADDRESS Near Sykesville
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print) First JOHN Middle DANIEL Last WHIPP | | | 4. DATE OF DEATH
Month April Day 20 Year 1966 | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1 March 1884 | | 9. AGE (In years last birthday) 82 yrs.
IF UNDER 1 YEAR: Months Days Hours Min.
IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Farmer | | | 10b. KIND OF BUSINESS OR INDUSTRY Farm Owner | | 11. BIRTHPLACE (County & State, or foreign country) Adamstown, Md. | | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME John N. Whipp | | | | | 14. MOTHER'S MAIDEN NAME Maria Shellman | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. 219-36-2620 | | 17. INFORMANT Mrs. Dora S. Whipp (Same as item #1)
Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage, left
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension, arteriosclerosis generalized
DUE TO (c) Cardiac failure | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1965 to 4-20-66 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1965 , 19 4-20 , 19 66 , that (I) (we) last saw the deceased alive on 4-20 , 19 66 , and that death occurred at 4:00 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Howard E. Hall | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 20 April 1966 | |
| 22c. PHYSICIAN'S NAME (Type) HOWARD E. HALL | | | | | | 22d. ADDRESS Sykesville, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4-23-66 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | | 23d. LOCATION (City, town or county) (State) Frederick, Md. 21701 | | |
| 24. FUNERAL DIRECTOR Frank R. Smith Jr.
M. R. Etchison & Son, Frederick, Md. 21701 | | | | 25a. REC'D BY REGISTRAR APR 25 1966 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

1951

Carroll

Sykesville Md

West Sykesville

Sykesville Md

West Sykesville

1

John H. Wright

Carroll County

Carroll County

John H. Wright

John H. Wright, Carroll County, Md.

1951

John H. Wright, Carroll County, Md.

John H. Wright, Carroll County, Md.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05162

05161

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Finksburg RD #2
c. LENGTH OF STAY IN 1b
14 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE
Maryland
b. COUNTY
Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Finksburg RD #2
d. STREET ADDRESS
Box 410
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
JAMES | | First
WHITE | | Middle
WHITE | | Last
WHITE | | 4. DATE OF DEATH
Month
April
Day
28
Year
1966 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 17, 1917 | | 9. AGE (In years last birthday)
49 yrs. | | IF UNDER 1 YEAR
Months
Days
Hours
Mins. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
auto mechanic | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Nat'l Dairies | | 11. BIRTHPLACE (County & State, or foreign country)
Jeannette, Pa. | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William White | | | | 14. MOTHER'S MAIDEN NAME
Nora McCarthy | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
-- | | 16. SOCIAL SECURITY NO.
209-09-3388 | | 17. INFORMANT
Mrs. Beatrice V. White | | | | Address
same | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Angina Pectoris
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 min.
2 hrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
none | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. none 19
p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (the hospital) attended the deceased from 1-7-55 , 19__, to 4-28-66 , 19__, that (I) (we) last saw the deceased alive on Apr. 28 , 19 66 , and that death occurred at 9 A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
D. D. Caples | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED
4-28-66 | | | |
| 22c. PHYSICIAN'S NAME (Type)
D. D. Caples, M. D. | | | | 22d. ADDRESS
6 Hanover Rd., Reisterstown, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE THEREOF
5/2/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Memorial Gardens | | | | 23d. LOCATION (City, town or county) (State)
Finksburg, Md. | | | |
| 24. FUNERAL DIRECTOR
J. S. Myers, Jr., Westminster, Md. | | | | 25a. REC'D BY REGISTRAR
MAY 2 1966 | | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|----------------------------------|--|---|---|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 05163 | | | | | | | | | |
| 05162 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN 1b
3 mos. 26 dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Savage
d. STREET ADDRESS
305 Commercial Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
CHARLES WILLIAM WHITEHEAD | | | | | 4. DATE OF DEATH
Month
April
Day
20
Year
19 66 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11-20-09 | | 9. AGE (In years last birthday)
56 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Janitor | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Julius C. Whitehead | | | | | 14. MOTHER'S MAIDEN NAME
Clara M. Waskey | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) yes
(If yes give war or dates of service) 1941-1942 | | | | | 16. SOCIAL SECURITY NO.
213-01-7709 | | 17. INFORMANT
Records, Springfield State Hospital
Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RETICULUM CELL SARCOMA OF LEFT TONSIL WITH NECK METASTASIS
2000
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-24-65 , 19 65 , to 4-20-66 , 19 66 , that (I) (we) last saw the deceased alive on 4-20-66 , 19 66 , and that death occurred at 2:20 p.m. , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Octavio A. Ruiz
M.D. | | | | | 22b. DATE SIGNED
4-20-66
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Octavio A. Ruiz, M.D. | | | | | 22d. ADDRESS
Springfield State Hospital
Sykesville, Maryland 21784 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
4-23-66 | | 23c. NAME OF CEMETERY OR CREMATORY
Savage Cem | | 23d. LOCATION (City, town or county) (State)
Savage Md. | | |
| 24. FUNERAL DIRECTOR
William H. ...
ADDRESS | | | | | 25a. REC'D BY REGISTRAR
APR 29 1966
DATE | | | | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | |

0518

General

St. Louis

St. Louis State Hospital

St. Louis, Mo.

St. Louis

St. Louis

St. Louis, Mo.

St. Louis

St. Louis, Mo.

St. Louis

St. Louis

St. Louis, Mo.

APR 21 1938

CERTIFICATE OF DEATH

05164

05163

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural--Sykesville | | c. LENGTH OF STAY IN 1b
13 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cresaptown | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Springfield State Hospital | | | | d. STREET ADDRESS
-- | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Mary Belle Zarger | | | | 4. DATE OF DEATH
Month Day Year
4 17 19 66 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
6/10/86 | | 9. AGE (In years at birthday)
79 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland--Artemas, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Simon Clingerman | | | | 14. MOTHER'S MAIDEN NAME
Eliza Leasere | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT Address
Springfield Hospital records--Sykesville | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure due to myocardial infarction days
DUE TO (b) Arteriosclerotic cardiovascular disease years
DUE TO (c) Chronic bronchitis years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Chronic brain syndrome associated with senile brain disease with psychotic reaction. | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from 4/4/ , 19 66 , to 4/17/ , 19 66 , that (we) last saw the deceased alive on 4/17/ , 19 66 , and that death occurred at 11:30P M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Maneeratana Fuangvudhiran</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
4/17/66 | |
| 22c. PHYSICIAN'S NAME (Type)
Maneeratana Fuangvudhiran, M.D. | | | | 22d. ADDRESS
Springfield State Hospital Sykesville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
April 21, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Md. | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | | | 25a. RECEIVED BY REGISTRAR
APR 20 1966 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

SECRET

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 05165 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY CARROLL | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
RURAL Sykesville | | | | c. LENGTH OF STAY IN 1b
1 Month | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
R Sykesville | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Linger Nursing Home | | | | | | d. STREET ADDRESS
Springfield Ave. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Frederick W. Middle Zimmerman Last | | | | | | 4. DATE OF DEATH
Month April Day 25 Year 1966 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8-26-1886 | | 9. AGE (in years last birthday)
79 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
FARM | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Zachary Zimmerman | | | | | | 14. MOTHER'S MAIDEN NAME
Annie C. Baer | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO.
7 | | 17. INFORMANT
Address Mrs. Nellie Zimmerman - Sykesville, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4342 Pulmonary Edema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arricular fibrillation
DUE TO (c) Cardiac Asthma
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary Infection. Generalized thrombosis | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 26, 1965 to APR 25, 1966 , that (I) (we) last saw the deceased alive on APR 25, 1966 , and that death occurred at 1:30 PM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Sani Okutman | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4.26.1966 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Sani Okutman | | | | | | 22d. ADDRESS
Sykesville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE THEREOF
4-28-66 | | 23c. NAME OF CEMETERY OR CREMATORY
LAKEVIEW Cemetery | | | 23d. LOCATION (City, town or county) (State)
Sykesville, Md. | | |
| 24. FUNERAL DIRECTOR
Harry W. Haight | | | | | | ADDRESS
Sykesville, Md. | | 25a. REC'D BY REGISTRAR
MAY 2 1966 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

